DOCUMENT RESUME

ED 324 625 CG 022 887

AUTHOR Brown, Duane; And Others
TITLE Handbook of Consultation with Individuals and Small Groups.
INSTITUTION Association for Counselor Education and Supervision, Washington, D. C.
REPORT NO ISBN-1-55620-049-8
PUB DATE 88
NOTE 98p.
AVAILABLE FROM Association for Counselor Education and Supervision, 5999 Stevenson Ave., Alexandria, VA 22304 (Order No. 72295, $9.95).
PUB TYPE Guides - General (050)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Consultants; *Counselors; *Counselor Training; Higher Education; *Supervision; *Supervisors

ABSTRACT

This handbook is one of four handbooks developed for preservice and inservice counselor preparation and professional development. It was developed as a practical guide for practicing professionals and as a textbook or supplementary material for use in courses or workshops on consultation. Chapter 1 provides an introduction to consultation, defining the term and explaining why consultation is valuable. Chapter 2 outlines basic facilitative skills and focuses on developing the consulting relationship, looking at the pre-relationship, initiating the relationship, structuring the consultation, communication skills, and possible cross-cultural concerns. Chapter 3 concentrates on problem identification and goal setting in consultation. Types of data needed to define the client's problem are discussed and systems for classifying problems are explained. A section on goal setting is followed by a discussion of crisis and consultation. Chapter 4 presents various consultation interventions for use with individuals and groups. Chapter 5 focuses on evaluation of consultation, presenting both extensive and intensive evaluation designs and discussing some useful evaluation instruments. Different issues in consultation are considered in chapter 6, including internal consulting, supervising consultants in training, and the consultant as a private practitioner. Chapter 7 looks at ethical and legal considerations in consultation. References are included. (NB)

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ASSOCIATION FOR COUNSELOR EDUCATION AND SUPERVISION

Handbook of Consultation With Individuals and Small Groups

Handbook of Consultation With Individuals and Small Groups

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A Publication of the
Association for Counselor Education and Supervision
1988

A Division of the
American Association for Counseling and Development
5999 Stevenson Avenue
Alexandria, Virginia 22304

Order No. 72295

International Standard Book Number 1-55620-049-8

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Association for Counselor Education and Supervision

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Second Printing 1989
Third Printing 1990

Foreword

The Association for Counselor Education and Supervision is proud to add two handbooks to a growing series of practical publications offered for preservice and inservice counselor preparation and professional development. Two earlier publications, *Handbook of Counseling Supervision* and *Handbook of Administrative Supervision,* published in 1987 have been received with great enthusiasm and have outsold all expectations to date. These new handbooks, *Handbook of—Consultation with Individuals and Small Groups* and *Consultation: An Intervention for Outreach and Advocacy* are offered for your consumption and use in emphasizing the growing consultant role many practitioners are exercising.

It wasn't too many years back when field practicum was an exception to the rule and internships were unheard of; perhaps this is where consultation preparation is today. A small but growing number of counselor preparation programs have introduced coursework that emphasizes this important role. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) includes consultation as one of its required competencies. To date 49 counselor education programs throughout the country are CACREP approved. A growing body of research and literature is accumulating to support this ever expanding role of the counselor as can be seen by the list of references in this handbook.

As counselor educators, supervisors, and practicing counselors we find ourselves serving as consultants to a multifaceted clientele including, but not limited to, educational institutions, business and industry, human services agencies, legislative bodies, government agencies, allied professional associations, students, families, and many other individuals and groups. We also, in a peer relationship, serve as consultants to each other. Through some very painful lessons, for example, substance abuse, teen pregnancy, AIDS, teen suicide, structural unemployment, and human rights infringements, the public has at last discovered the need for the services available for

competent counselors. And, as we are called upon more frequently to testify, justify, and defend, we need to polish our consultation skills.

These handbooks will be useful as supplemental texts for courses and workshops in consultation and as helpful guides for practicing professionals. A very special note of gratitude is directed toward the better than 100 members of the ACES Consultation Network for fostering this important role of the counselor. Under the leadership of co-chairs Duane Brown and Jan Gill-Wigal this network has conducted research and promoted the need for counselors to be prepared as consultants. A special thanks is offered to Duane Brown, DeWayne Kurpius, and Joseph Morris, authors of the *Handbook of Consultation with Individuals and Groups;* and again to Duane and DeWayne for editing, *Consultation: An Intervention for Outreach and Advocacy.* The contributors to this second handbook are also commended for their excellent contributions. ACES is fortunate to have these dedicated professionals who have given of their time and talents to bring us these very useful products. The ACES Media Committee members who reviewed the manuscripts in a very timely fashion are also recognized for their helpful feedback.

Joseph C. Rotter, 1987-1988 President
Association for Counselor Education and Supervision

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Chapter One

Introduction to Consultation

The history of consultation can be traced to two distinctive origins (Gallessich, 1982). One can be identified by examining the organizational development literature and tracing a historical path to Kurt Lewin, Carl Rogers, and a number of organizational and management theorists. This root quite obviously deals with organizational development consultation, where the consultant works with a manager or management team to improve the functioning of some aspect of the organization. The other root is focused on improving mental health services and practices, and while it can be traced to the turn of the century, its greatest impetus was provided by Gerald Caplan in 1970 with the publication of his book, *The Theory and Practice of Mental Health Consultation.*

This handbook will draw from both of consultation's historical beginnings, but by necessity, because of length, will focus upon consultation with individuals and small groups, rather than organizations. This in no way suggests that the content of the volume is not relevant to the work of the organizational consultant. It does suggest that the consultant working in schools and community agencies may benefit most from its contents.

Consultation as a practice is in its infancy, both in terms of theory and practice. One consultant likened the current status of the field to that of the group literature in the sixties. Group counseling could mean anything from guidance groups which were highly structured to encounter sessions where little or no structure was imposed. Two people conversing about groups in that era often found that they had to define their terms before they could have a meaningful exchange of ideas. And so it is with consultation today and, thus, defining what is meant by consultation becomes our first task.

Consultation Defined

Recently, one author called for an end to articles on consultation because consultation is well understood. By implication, the same author also indicated that almost anyone can be a consultant and, in fact, consultation has been going on since Moses consulted with God. While one suspects that Weinrach (1987) had his tongue planted firmly in his cheek when he was writing about consultation, his view is not far from that held by many counselors, that is, consultation is viewed very simplistically. As Gallessich (1982) notes, consultation, when used colloquially, is equated with advice-giving.

In fact, consultation is a complex process that requires special training because of the numerous knowledge bases and a wide range of skills including many of those required in the counseling, teaching, and supervision processes also utilized by many members of the helping professions. Defining consultation is difficult because of its newness and complexity. It is also difficult because of the various stances a consultant may take within consultation. For example, consultants may act as experts, in which case they dominate certain aspects of the process. On the other hand, they may assume positions as process consultants (Schein, 1969), in which case they are primarily responsible for helping consultees formulate their own questions and identifying their own problems. The result of the complexity and the variability in the roles that consultants may play is that any definition of consultation tendered here is open to criticism because the authors probably have overlooked some nuance of the process.

Consultation, like supervision, is a triadic process where the consultant and the consultee work together to develop a strategy for helping a third party—the client. Consultation, also like supervision, has a parallel agenda, that being to enable the consultee to deal more effectively with similar clients in the future. Therefore, the hoped for outcomes in both supervision and consultation are that the third party's (client's) needs are met while the consultee and trainee become more proficient (Brown, Pryzwansky, & Schulte, 1987; Kurpius & Robinson, 1978).

Consultation and supervision differ on one important dimension: evaluation. Inherent in the supervisory process is the supervisor's evaluation responsibility. In some instances where supervision is entered into voluntarily, the impact of evaluation in supervision upon the trainee is minimal. However, in most instances, the supervisor's evaluation is very important to the client, in that future career, promotions, licenses, etc. are dependent upon the outcomes of the evaluation. Supervisors have greater power than trainees as a result. While power relationships may vary, the consultee is never in the one-down relationship in which supervisees find themselves. In fact, one of the goals of consultation is the equalization of power (Caplan, 1970; Brown et al., 1987).

The difference between consultation and teaching and counseling is more obvious. Both teaching and counseling are strategies where helpers work directly with a client or clients to bring about changes. In the case of counseling, the client has usually agreed to the change process. In teaching, agreement must be sought in some situations. No improvement in functioning is expected in the counselor or teacher as a result of the respective processes, although enhanced functioning may occur as a result of preparing and delivering either counseling or instruction.

Consultation is, then, a triadic process between a consultant and a consultee in which the power relationship is equitable. Caplan (1970) referred to this as a coordinate relationship. The client may be an individual, small group, organization, or community (Lippitt & Lippitt, 1978). Not many current consultants would disagree with this aspect of the definition of consultation, but there are other facets of a comprehensive definition of consultation that are not so readily accepted by everyone in the field.

Caplan (1970) set forth the idea that consultation is a process that takes place between two professionals and focuses on work-related problems. Many people still accept these notions (e.g., Altrocchi, 1972; Gallessich, 1982), but increasingly, the idea that consultation occurs only between two professionals has been called into question. Lippitt and Lippitt (1978) suggest that consultation can occur with parents and only recently, an entire volume was devoted to this subject (Wyne, McDaniel, & Weber, 1986). Some of Heller and Monahan's (1977) work in community psychology also suggests that consultation can occur between leaders of indigent community groups to help them assert themselves within a community. Brown, Wyne, Blackwell, and Powell (1979) discussed consulting with student leaders and groups as one means of solving certain problems in schools. While consultation may occur more often in work settings, it is not necessarily restricted to professionals. Rather, it can occur between a professional and a non-professional individual or group in community and other non-work settings as well.

The focus of consultation is a work problem, but work may not be as narrowly defined as Caplan (1970) intended. His consultation model focused consultation in the delivery of mental health services by the consultee. Here, the meaning of work is taken to be a process engaged in by the consultee that relates to the client. However, "work" may involve parenting, designing a program, the delivery of mental health services, the management of an organization, or mobilizing a school club to assist underachievers. Consultation is seen as a process where the consultant works in concert with the consultee to enhance their functioning with a client by helping them improve their technical or human relations skills. In some instances, this occurs simply as a result of assisting consultees to mobilize their strengths or to tap resources readily available in their environment. In others, the consultant is more directly involved in a teaching/modeling process.

The emphasis in the foregoing paragraph is upon increasing the functioning of the consultee, but there are limits to the manner in which this can be accomplished. Caplan (1970) set forth one principle that consultants have endorsed: counseling the consultee is to be avoided. Caplan first developed mental health consultation as a means of improving the efficiency of delivery of broadly defined mental health services. Engaging in counseling or therapy with the consultee sidetracks consultation from its basic mission, which is to improve services to an individual, small group, or organization.

In all human processes, the matter of values must be addressed. In teaching, instructors' values predominate since they choose the material, method, and objectives for the learning process, although this may be tempered in some situations. Supervision is much like instruction in that the supervisor's values are dominant. In consultation, consultants must understand their own values before they can begin to understand the values and needs of the consultee and contribute to the growth and development of the consultee and the consultee's client.

Consultation has been referred to as a process throughout this section. In fact, it can probably best be characterized as a problem solving process (Bergan, 1977; Brown et al., 1987) which includes relationship development, data gathering, problem identification, goal setting, strategy selection and implementation, evaluation, and often, recycling of the process. The process is not necessarily a linear one, however. In fact, some of the substages of consultation occur simultaneously and, at times, it is necessary to return to an earlier stage (e.g., from problem resolution to relationship), particularly if the relationship has not been well developed, or from problem resolution to problem identification if problem definition has not been conducted carefully.

It is not enough to think of consultation as a series of five or six steps, however. In fact, there are two interlinked sub-processes occurring, one between the consultee and consultant, and one between the consultee and client. These processes do not occur simultaneously in that the process involving the consultant and consultee is temporally ahead of the client and the consultee process. To illustrate, once the relationship between the consultee and consultant is established, the presenting problem identified, and the intended goals established, the *restructuring* of the client-consultee relationship is initiated. Problem identification involves both identifying the nature of the client's problem, and the reasons why the consultee is having difficulty coping with the problem, and must be completed before the intervention with the consultee, and client, can begin. This can be a delicate process because the consultant will want the consultee to objectify the data presented by the consultee about the client.

The final stage, evaluation, runs parallel to the client-consultee process. The consultee is evaluating self (with help from the consultant) to determine the consultant's effectiveness, as well as evaluating the client to determine his or her progress in that realm. Ultimately, evaluation of the consultee's progress is, in fact, dependent upon an evaluation of the client's process. If consultation is successful, consultees usually have become more skillful, insightful, and knowledgeable, and both the present and future clients benefit.

The involvement of the consultee and the consultant in each stage of the consultation process will be dependent upon a variety of factors. In some models such as mental health consultation (Caplan, 1970), the consultant withdraws after the generation of strategies, and the consultee is left to his or her own devices to implement the strategies developed. Many consultants would argue for involvement of the consultant in each stage of the process. Research with some consultee groups, such as teachers, has indicated that they are more comfortable with the collaborative approach to consultation (Babcock, & Pryzwansky, 1983; Wenger, 1979). Consultee and consultant preferences, as well as the model being utilized by the consultee, will determine whether the consultee withdraws after problem solutions are generated or continues a thorough strategy implementation and evaluation. The degree of involvement between the consultant and consultee needs to be set forth in the "formal" and reinforced in the "informal" consultation contract.

The discussion thus far has treated consultation as though is has no contextual variables beyond those of the consultant, consultee, and client. In fact, organization or systems variables do not have a dramatic impact upon the consultation process, even when the organization is the client. So do variables external to the organization. Gallessich (1979), Conoley (1981), Sarason (1982), Kurpius (1985), and Brown et al. (1987) have discussed these variables, with the latter group of authors identifying over a dozen intrasystem and extrasystem variables that influence the consultation.

The informal norms of the institution, the governance structure, the clarity of roles within the organization, the demographic characteristics of the people who work in the organization, reward systems, and decision making patterns are a form of the intrasystem variables that will influence the consultation process. For example, if the supervisor expects employees to solve their own problems, consultation opportunities are likely to be reduced. Also, if there is strong individual competition, developing linkages between consultees and more proficient workers is difficult.

Extrasystem variables such as union contracts, legislation and local ordinances, economic and political climate, advocacy groups, and accrediting bodies also influence consultation. For example, union contracts may specify roles, dictate overtime policy, and in doing so, preclude the development of certain kinds of programs. Accrediting

bodies also place restrictions on personnel, programs, and facilities and may limit the degrees of freedom of the consultant and consultee. Economic and political climate may dampen enthusiasm for change and innovation as well.

Consultation does not occur in a vacuum. It occurs within a social system that has boundaries, goals, expectations, governance structures, informal norms, and utilizes certain technologies. This organization is, in turn, a part of a suprasystem that not only provides human and other resources, but produces a climate that influences attitudes and actions within the system.

To complicate matters even more, consultants, consultees, and clients are part of other systems such as families and communities that influence their functioning. For example, it would be ludicrous to act as through students have no relationship to their families, or consultees are not influenced by their churches or work settings.

The exact nature of the influence of intrasystem or extrasystem variables is difficult to predict. Preparedness requires only that the consultant and consultee realize the potential influence of these variables upon the process, and that they act in ways that either offset these variables if they expect them to retard the process, or take advantage of them if they can facilitate the process.

A Definition

Consultation occurs within a systems context that must be considered at each step in the process.

It is a problem solving process aimed at enhancing the functioning of an individual, small group, or organization, with primary focus on the consultee who they can work effectively with similar problems in the future. Since the process is value- and concept-driven, it is imperative that the consultant and consultee values and conceptual framework that influence their actions be made explicit. The power relationship between the consultant and consultee should be equitable so far as the process is concerned, although it is recognized that, ultimately, the consultee has the prerogative of rejecting all that is generated in the consulting process. Finally, the degree of involvement of the consultant will depend upon a variety of factors, including the context circumstances, the model being employed by the consultant, and the preferences of the consultant and consultee. However, it is generally recommended that a collaborative approach be followed which involves the consultant in each stage of the process.

Why Consultation?

Consultation offers counselors and other helpers a means of intervening in the lives of client groups afforded by no other intervention. In counseling, clients may be helped to overcome personal problems and function more effectively in their environments. Through consultation, clients can be helped to

overcome personal deficits, and the environmental influence controlled by the consultee can be altered simultaneously. Supervisors can be helped to design and deliver better performance appraisal programmed, and develop job enrichment programs that will have consequences for large numbers of clients. Parents can learn to teach their children social skills while creating a home environment conducive for the practice of those skills. Teachers can learn to act similarly with their students.

Through consultation, primary prevention programs can be developed that will contribute to work, family, and educational environments that will be less likely to contribute to dysfunctional living. Parents who learn to deal with an underachieving child may be better able to prevent that syndrome in the future with their other children. Employers who inadvertently create stressful environments may be able to increase commitment and reduce absenteeism, tardiness, and reduce health care costs simply by restructuring the workplace. Consultants have helped teachers, parents, employees and others become effective agents against mental health problems.

Reynolds, Gutkin, Elliot & Witt (1984) summarized the literature that compared consultation with counseling interventions and concluded that consultation has an edge, particularly when one considered the amount of time required to provide counseling services. While the research to date has primarily compared consulting with teachers and parents to counseling students directly, the evidence is provocative enough that even the most skeptical must consider the possibility that when cost, efficiency, and ability to impact client behavior are considered, it is quite possible that consultation may be superior to counseling.

Summary

Consultation has not been well-defined, partially because of its newness, and partially because it has evolved out of two separate areas of study. That situation is rapidly being corrected and there is much agreement about the nature of consultation and how it should be defined.

Chapter Two

Developing the Consulting Relationship

Some consultants, such as Bergan (1977), have ignored relationship variables in consultation, choosing to begin their discussion of the process with problem identification. Others such as Caplan (1970), Martin (1978), and Randolph (1985) have suggested that ignoring the relationship is a significant omission, and research by Bergan and Tombari (1976), Schowengerdt, Fine and Poggio, and Grantham and Wright (1979) provides evidence that relationship variables are, in fact, important. Opinions by experts and research suggest that several relationship factors should be addressed in consultation. Those to be considered here involve pre-relationship variables, basic communication skills, structuring, power equalization skills, the avoidance of counseling and psychotherapy, and cross-cultural issues.

Pre-Relationship

Consultants enter from both within and outside of the organization in which they may work. For consultants who are already part of an organization such as a school or an agency, the pre-relationship stage of consultation poses fewer problems. They can be contacted easily, need cross no organizational boundaries, and usually are, to some extent, a known quantity. In fact, internal consultants may initiate the consultation.

Other consultants come from the outside as a result of contractual agreements between agencies. A mental health center may agree to provide consultation services to schools, adolescent custodial care institutions, and businesses of various types. In these cases, the agency providing the services may select those most qualified to provide consultation. In still other situations, external consultants are contacted and asked to provide consultation services for specific problems and goals.

In each of these situations it is important to clarify expectations. Consultees are often unaware of the nature of the consultation process, particularly with regard to the important role they play in it. They may also have unrealistic expectations regarding the role and influence of the consultant. Brown et al. (1987) report that one consultee complained, "He never told me what to do." Consultant and consultee need a common set of expectations before consultation can proceed successfully.

In some instances, such matters as fees, expenses, provision of secretarial services, time needed, and space, and the nature and timing of reports will also have to be settled before formal consultation can begin, although in reality, these negotiations mark the beginning of the process. Consultants also need to clarify that information gained in the initial consultation process will be held in confidence prior to the formal initiation of consultation. This matter will be taken up in greater depth in a subsequent chapter.

Actually accomplishing these pre-consultation tasks requires that the consultant (1) communicate clearly how he/she perceives the consultation process, (2) clarify the role responsibility of the consultee, (3) discuss the role of the consultant and consultee with the client, (4) formally or informally agree upon time, place, fees, expense, and services to be provided by each party and reports to be filed, and (5) clarify ethical matters such as the confidentiality of material gained. The formality of the contract will often be related to whether or not consultants are to be paid directly for their services, but the other provisions of the contract are just as important as compensation and should not be ignored.

Initiating the Relationship

The skills required to initiate a consulting relationship are very similar to those needed in other helping situations. As Carkhuff (1983) has noted, "attending is the necessary pre-condition of helping" p. 24. Attending involves physically attending (through body posture, forward lean, squarely facing the consultee) and eye contact. It also involves readying ourselves for the consultee by reviewing information that may be pertinent to the consultation, making certain that the setting in which the consultation is to occur is comfortable, and avoiding interruptions once the session has begun by alerting secretaries or others that the consultation is to occur (Carkhuff, 1983).

Initiating consultation also involves dealing with issues that have not been dealt with in the pre-relationship phase. In any case, the matter of confidentiality should be reviewed to make certain that the consultee understands that the information they disclose will be held in confidence. If others are to be involved, the consultee should also know that information gained from them will not be disclosed without permission. It is particularly important, if the consultees are supervisors, that they also be enlisted in communicating confidentiality agreements to those being supervised.

Initiating the consultation relationship also requires that details such as where and when consultations are to occur be determined. The consultee's schedule should be given utmost consideration in determining the time, and the place should be a mutually agreed-upon location. When the consultant is external to the organization, the place will typically be where the consultee is employed, that is, when settling details, the consultee's wishes should be of major concern.

Structuring Consultation

Structuring consultation involves setting up role expectations. In a very real sense, this process begins with the first contact and continues throughout the consulting process. Structuring occurs on two levels: explicit and implicit. Explicit structuring occurs when either the consultant or the consultee makes reference to their role. The following is an example of a set of structuring statements:

Consultant	I see this as an effort between equals. I bring some knowledge and background because of my training and experience. You also have training and experience plus a great deal of experience in this setting.
Consultee	I certainly don't feel like your equal. I know a lot about the situation, but you have a lot of experience in other settings.
Consultant	You feel like you are less important in this situation, but I believe you are underestimating your own background and experiences. Let's talk about what you have done.

The consultant is trying to equalize the power in the relationship at the outset. For the moment, the consultee is not feeling as though he/she is an equal, but the consultant should continue to reinforce an equitable relationship until understanding and agreement is reached regarding the relative status of the consultant and consultee.

Once explicit agreements regarding power are reached (or any other aspect of the consultation), consultants must honor those contracts through implicit structuring. For example, the internal consultant may take responsibility for scheduling the meeting rooms and other details of the consultation, thus communicating their intent to "take charge" of the consultation, and unwittingly destroy the power balance. In other instances, consultants may too readily exhibit their expertise and intimidate the consultee in the process.

Parsons and Meyers (1984) have made several explicit suggestions directed to enhancing consultee-consultant collaboration. These include:

1. Allow the consultee freedom to accept or reject ideas advanced by the consultant
2. Encourage the consultee to contribute suggestions
3. Encourage the consultee to make decisions

4. Emphasize the consultee's contributions
5. Encourage consultee responsibility
6. Require effort from the consultee (pp. 38-39).

The power relationship must be structured. So must a related concern, the roles that the consultee and consultant are to play at each stage of the consultation. Questions such as who will collect information regarding the client and how interventions are to be implemented will loom constantly, and will have to be dealt with by the consultant and consultee. Here again, the over-eager consultant can destroy the explicit agreement by acting in a fashion that is contradictory to it.

Another aspect of structuring the relationship is defining consultation so that both parties have a clear understanding of the process. Structuring statements such as:

> I see consultation as a joint venture where you and I work collaboratively to solve the problem(s) we identify. We will work together both to identify the problem and then to solve it. Evaluation should also be a joint venture. I guess I have another expectation as well. That is that you and I will learn together as a result of our work together.

In Chapter One, it was mentioned that counseling the consultee is to be avoided. Early implicit structuring by focusing on the client can be helpful to avoid counseling the consultee. In so far as possible, introductory statements should focus on the primary purpose of consultation: helping the client. Some examples might include:

Consultant (with parent)	Our purpose here is to focus on your concern for your child. Our hoped-for outcome is that we can reduce Johnny's bed-wetting.
Consultant (with teacher)	It's frustrating when children don't learn as well as you expect. Carol is our primary concern, and if our work together is successful, improvement in her achievement should be obvious.

Communication Skills

As stated earlier, the communication skills needed by a successful consultant are quite similar to those required in counseling, with one major exception. Consultants need an awareness of the differences in order to avoid counseling the consultee. First, consideration will be given to the basic communication skills needed by the consultant. In Figure 1 can be seen a summary of the helping model developed by Carkhuff (1983). The core helping conditions include empathy, respect, genuineness, and concreteness or specificity.

Empathy involves the ability to understand the internal frame of reference of the consultee and communicate that understanding. The

level of this communication varies with the stage of the helping process. In the pre-helping stage, communicating empathy involves identifying the needs of the consultee for basic information about the consultation and where it is to occur, and providing the necessary information. In Phase I, Exploration, responding with empathy requires the consultant to be able to identify the salient content and the affect associated with it and response, interchangeably, that is, communicate to the consultant that the content and associated emotion are understood. Personalizing communication involves helping the consultee make "personal sense" out of his or her experiences, and responding with immediacy requires the consultant to focus on how the consultee is experiencing the consulting relationship as it relates to his/her life (Carkhuff, 1983). Example of empathic responses at each phase follow:

Pre-helping	You seem a bit confused about the nature of consultation. Let me clarify it for you further. Then let's see if the confusion clears up.
Exploration	It's really quite frustrating when your suggestions for improving things go unnoticed.
Understanding	You're quite apathetic because of a number of variables related to the way the university functions, but the low priority placed on student services is the one area that is most disturbing to you.
Recycling	You are a little uncertain about the consulting relationship and how you and I are to work together to meet our goals.

Respect is the core condition that relates to prizing consultees because of their worth as human beings. Initially, it is important to suspend one's values, a task that can be difficult at times, if the consultee is an abusive parent, a tyrannical employer, or a teacher who is only minimally concerned about students. During the exploration phase, unconditional positive regard needs to be communicated. This gives way to conditional regard in the understanding phase. Demonstrating unconditional positive regard means suspending one's values and accepting both the consultee and his or her acts. Communicating conditional positive regard involves separating some of the actions from the actor. An abusive parent has a right to respect as a human being, but his or her abusive behavior need not, and indeed should not, be accepted by the consultant. The following are examples of communication involving respect with an abusive parent.

Pre-helping	I'm delighted that we are having this opportunity to work together. (I prize you.)
Exploration	(After disclosure about abusing a child.) You became quite angry and struck Michelle a number of times. (I accept you.)

Understanding	(After disclosure about abusing a child.) You became quite angry and struck Michelle. Now you say, and I agree, that hitting her repeatedly was wrong. (I accept you but I cannot accept your actions.)

Genuineness is related to respect to some degree. Genuineness refers to the extent to which the consultant responds, according to his or her own values. Early in consultation, personal opinions, emotions, and values are suspended, and while the consultant does not respond ingenuinely (dishonestly), many typical reactions are held in abeyance. However, with each succeeding stage of the consultation process, the consultant becomes more genuine, until in the Exploration stage, the consultant becomes fully genuine. The following are examples of consultant communications at various stages of consultation.

Pre-helping	(After a question about consultant's view on corporal punishment.) Well, I tend to look at the research literature and I do have some questions about the value of it.
Exploration	Corporal punishment doesn't seem to be getting the job done in your classroom.
Understanding	It seems to me that you have misjudged the effect paddling has had on Jamie. He now fears you and so it's more difficult to reach him.
Action & Recycling	Actually, what you have done to Jamie should be stopped and I am ready to actively help you to redefine the problem and the situation.

Concreteness is the core condition that involves assisting consultees to specify the nature of their problems and their feelings about it (Carkhuff, 1983). It requires that the consultant be able to identify the major themes in the consultee communication, help the consultee synthesize whenever possible, and then identify the parameters of the theme(s). Early on, concreteness requires only that the consultee's specific information through direct questions and clarifications (tell me more) leads. In the action phase, it is imperative that the four important parameters of the dominant theme(s) be identified. (1— With whom does the problem occur? (2) What is the exact nature of the problem? (3) Where does the problem occur?, and (4) Why is it a problem?

As can be seen, both in Figure 1 and in the foregoing discussion, the nature of the consultant's function changes as the relationship progresses. Carhuff (1983) attributes this to the development of an interchangeable base of communication. As the consultant communicates empathy, that is, responding accurately to both the content and the affect of the consultee, the relationship is strengthened. This strength enables the consultant to function more genuinely and to become an active participant in assisting the consultee to clarify the nature of the concern. In most consultations,

this interchangeable base develops quite rapidly. Behavioral signs that the relationship is advancing include relaxation of arms, hands, and legs, a less rigid posture, more smiles, less guarded communication, disclosure of sensitive data and feelings, and owning feelings, behaviors, and attitudes. However, the rapport is not usually established immediately and may take two or three sessions to establish. If it cannot be developed in this time frame, thought should be given the possible causal of consultative factors. Sometimes, termination and referral may be necessary.

As the relationship advances, disclosures of a more personal nature may occur. Some of these could result in redirecting the consultation to consultee therapy. Caplan (1970) admonished consultants to return to the safe ground of the client when it appears that consultation is moving to therapy. Randolph (1985) has developed a technique that he calls the supportive refocus for returning to this "so-called" safe ground. But, the more immediate question for some may be, "How do I know that I have moved from consultation to therapy?" Answer—when you are working on the personal problems of the consultee instead of helping the consultee to cope more effectively with the client. The nature of the client's problem is safe ground, as is the interaction between the client and the consultee. Consultee's personal problems, by and large, are off-limits, except as they relate to their specific functioning with the client.

At any time during consultation, the focus can shift from the client to the consultee. Take the following exchange:

Consultee	Trying to get a program together that works for these people is tough. Handicapped adults almost seem like a lost cause in our society.
Consultant	Sometimes it gets very frustrating when the chances of real success seem so remote.
Consultee	Yeah, I've redone this thing so often that I just feel hopeless. Maybe I'm just no good. Other people could probably do better.
Consultant	Things certainly look bleak at times and you feel bad about your failure. Let's discuss the program in greater detail to see if we can discover some strategies that will work.

This consultant has just engaged in a supportive refocus which Randolph (1985) describes as acknowledging the consultee's feelings, and then refocusing attention to the client, which, in this case, is the program for handicapped adults. Randolph goes on to indicate that in counseling or therapy, empathic responses are used to reinforce further self-exploration. What he does not point out is that, to some degree, this is true in consultation as well, but the consultant and consultee have two goals, only one of which can be served by counseling.

Figure 1. Carkhuff's Core Skills for Effective Helping

Core Conditions	Pre-helping Phase	Phase I Exploration	Phase II Understanding	Phase III Action	Phase IV Recycling
Empathy	Attending to immediate needs,	Responding interchangeably	Personalizing communication	Responding interchaneably	Responding with immediacy to relationship
Respect	Suspend values	Unconditional regard	Conditional regard	Conditional regard	Differential regard
Genuineness	Communicate self cautiously	No personal facade	Genuineness	Fully genuine	Fully genuine
Concreteness	Identifying specific immediate needs (e.g., information and meeting needs	Asking for specific information about concern	Identifying dimensions of problem	Being fully specific	Being programmatic
		Skills By Phase			
	1. Attending 2. Arranging context 3. Relaxing 4. Observing 5. Listening 6. Being non-judgmental	1. Responding to content a. Chronological b. Level of concern c. Cause & effect 2. Responding to feelings 3. Making meaning by putting content w/feeling 4. Suspending values 5. Identifying themes 6. Being non-judgmental 7. Increasing specificity of communication 8. Communicating respect	1. Identifying dominant themes 2. Assisting helpee to personalize & internalize 3. Confrontation to facilitate personalization 4. Assisting helpee to personalize goals 5. Communicating conditional regard 6. Becoming more genuine	1. Refining goals a. Who b. What c. Where d. When e. Why f. How 2. Design programs to achieve goals 3. Responding genuinely	1. Reviewing programs—revising as needed, rehearsing 2. Recylcing all previous steps to focus on new concerns 3. Being transparent 4. Focusing on one relationship between the helper and the helpee

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Carhuff, R.R. (1983). *The art of helping.*

There are times when counseling cannot be avoided, particularly if a personal problem stands in the way of progress with the client. Typically, consultation is terminated and a referral of the consultee is made to another counselor. However, some consultants will choose to reframe the nature of the relationship as personal counseling with the consultee, who then becomes the client. This is a delicate situation, and should not occur unless the consultee is unable to go to someone else. Even in this situation, it should be made clear that it is only a temporary change in focus, and that either a referral or return to consultation will occur in the near future.

Some Cross Cultural Concerns

Gibbs (1980), drawing primarily upon the counseling and therapy literature, presents the hypothesis that blacks and whites have different initial orientations to consultation. She believes that black consultees are more likely to respond positively to relationship variables, while white consultees are more likely to do what she terms instrumental competence, or the ability of the consultant to assist the consultee to advance toward a goal. Figure 2 summarizes the differences that Gibbs sees between white and black consultees. Her perceptions of the differences between black and white consultee can be summarized succinctly: black consultees prejudge interpersonal competency and then commit, while white consultees assess technical competencies prior to commitment to consultation.

The model portrayed in Figure 2 is untested, and therefore should be implemented cautiously. However, language differences and varying values perspectives are problematic in most human relationships. It seems unlikely that this would vary in cross-cultural situations. Consultants are well-advised to familiarize themselves with the cultural background of their consultees prior to entering the consulting relationship.

Pinto (1981) suggests that consultants may have an espoused cross-cultural perspective and an in-use perspective, and these may vary considerably. The in-use perspective must include cultural understanding and empathy as well as the ability to vary style and techniques to suit the culture of the consultee.

Summary

The facilitative skills already acquired by most counselors will suffice in the consulting relationship. One technique, the supportive refocus, needs to be learned because it is invaluable in avoiding counseling the consultee. Cross-cultural issues must also be considered in the consulting relationship, just as they are in counseling and other helping relationships.

Figure 2. Black and White Responses During the Five Substages of the Relationship

	Consultee Race	
Substage	**Black**	**White**
1. Appraisal	Evaluates interpersonal authenticity	Evaluates personal skills
2. Investigation	Inquires about personal attributes	Inquires about details of consultation
3. Involvement	Forms formal and informal personal relationships	Formal relationship solidified
4. Commitment	If expectations met, loyalty to consultant shifts to consultation task	Expresses commitment in terms of task
5. Engagement	Consultation task initiated	Consultation task initiated

Based on work by Gibbs, J. T. (1980).

Chapter 3

Problem Identification and Goal Setting

Problem identification and goal setting involve identifying the nature of the client's problem and the difficulty that the consultee is having in coping with the client, and establishing goals for solving both sets of problems. Bergan (1977) has developed an elaborate system for identifying the nature of the client's problem, and for establishing goals. Caplan (1970) has developed a taxonomy for classifying consultee problems, and provided guidelines for identifying them. These works, the social learning model of Brown, et. al (1987), and some general theories of human functioning will be drawn upon for this discussion. But before the actual mechanics of the problem solving and goal setting process are identified, some preliminary discussion of the process is in order.

In Chapter Two, the process of establishing the consultee-consultant relationship was discussed. This relationship was depicted as the first stage in a problem solving process that is followed by problem identification, goal setting, strategy solution and intervention, and evaluation. Consultation often involves plunging into immediate problem solving and, thus, relationship development and problem identification may occur somewhat simultaneously. Later in the process, usually at the intervention phase, the consultant may observe that resistance will occur, sometimes because the working relationship has not been fully developed. Therefore, it is not unusual for a consultant to find that information needed to assess problems has been withheld or distorted, or that information and true feelings have not been shared until later in the process. As a result, the problems involved are not accurately conceptualized. This requires that the relationship phase be revisited, the relationship be solidified, and the

problem solution be revised. It therefore becomes important that the consultant not neglect those basic facilitative skills outlined in Chapter Two.

Just as establishing a strong consultee-consultant relationship is necessary, defining the consultee's problem with the client is an obvious prerequisite to problem solving. Bergan and Tombari (1976) conducted a classic study in the factors that appear to influence problem definition. Two characteristics of consultants, efficiency and flexibility, were found to be related to problem identification. Efficiency in the context of their research refers to the ability of the consultant to immediately engage in the problem identification process. Flexibility relates to the application of psychological principles, i.e., consultants who were effective in solving problems were able to generate a number of plans and did not "force" the data received from the consultee into a narrow framework.

While it is not clear why efficiency was a factor in Bergan and Tombari's study other than the fact that the consultants who responded quickly may have found consultees who were ready to engage in consultation, consultant flexibility undoubtedly relates to the ability to tailor consultation to the consultee. Regardless of the mechanical aspects of problem diagnosis, it is recommended here that consultants develop a broad enough conceptual framework to be able to interpret data received from clients in a number of ways.

Role Relationships

Bergan (1977) assigns primary responsibility for assessing the nature of the client's problem to the consultee. Others (e.g., Brown et al., 1987) suggest that this is a shared responsibility. If equality in the power relationship is to be maintained, mutual responsibility for the diagnosis of the client's problem must be assumed.

It is often the case that the consultant possesses more knowledge and skills related to the diagnosis of clients' problems. However, it would be a mistake to assume that because a consultee has failed to solve the client's problem he/she has not diagnosed the problem correctly. Often the reason for the failure is the inability to design a proper intervention, or the goals established were inappropriate.

It would also be a mistake to discount the consultee's understanding of the variables that impact upon a client, particularly if the consultant comes into the organization from the outside. Even internal consultants may be less aware of the environmental circumstances and client characteristics that influence the client's functioning.

Finally, client's problems often fall into a category that can be termed interaction with the consultee. Consultees should be encouraged to look at these interactions and to diagnose them objectively. If we are to achieve our objective of helping the consultee deal with similar problems independently in the future,

insight into the consultee's role in the problem must be developed and reinforced. Insight development begins with diagnosis of the client's problem.

Defining the Client's Problem

Types of Data Needed

Block (1981) suggests that the goal of data-gathering is to develop a clear and simple picture of what may be causing the client's problem. The consultant should keep in mind that the presenting problem may not always be the *true* problem. Observation, and continually checking, refining, and narrowing down of the information gathered, will aid in implementation of appropriate strategies.

Bergan (1977) suggests that there are a number of categories of data needed about the client. The first of these is background-environment information. This may include historical antecedents of behavior which may be influencing the client at this time, as well as pertinent data from the current environment that may also be influencing the functioning of the client. A childhood illness may have so frightened a parent that they unwittingly began to pamper the child and have since given into his every demand. Thus, the behaviors of significant others in a setting may function to reinforce the behaviors of the client. It is important for the consultant and consultee to understand the significance of the client's interaction and the controlling environment.

The behavior-setting category includes the who, what, why, when, and where of the client's behavior. Who has the problem? What is it? How often does it occur? When does it occur? Where does it occur? Why does it occur or, put differently, what seems to trigger the behavior? And what, if anything, maintains or reinforces the behavior? Why does it persist? Bergan (1977) recommends that those questions be answered with great precision.

The individual-characteristics category deals with traits that may play an important role in the problem behavior (Bergan, 1977). Intelligence and learning disabilities play an important role in school-related behavior. Personality type (e.g., Type A) and interests may determine work satisfaction and/or management characteristics of the client may come from a variety of resources, including current files, consultee descriptions of the client, or from focused data collection efforts such as surveys and testing programs. Since not all necessary data about the client will be available, consultant and consultee will need to plan collaboratively to secure the data needed for the diagnosis of the client's problem.

It is also important to know what the consultee or others have tried before and what has been contemplated. If these plans have failed or suggestions have not been implemented, it is important to know why they were not implemented, or if they were implemented and failed, why the failure occurred (Bergan, 1977).

Parsons and Meyers (1984) and Brown et al. (1987) have suggested that the client's problem may be the result of the immediate environment (e.g., family, job setting), the larger environment (e.g., economic downturn), the client's characteristics (e.g., intelligence, stress), or the interaction between the client and the consultee or the client and his or her environment. In fact, it is likely that there will be multiple interactions when one finally determines the nature of the client's problem.

Classifying Client's Problems

A number of systems for classifying the consultee's problems could be advanced at this point. In reality, only three will be discussed: behavioral, social learning theory, and Adlerian.

Behaviorists tend not to use diagnostic categories. Rather, they tend to follow a process of (1) defining the problem in observable, measurable terms, (2) measuring the incidence and, if necessary, intensity of the problem, (3) identifying antecedent variables such as thoughts or environmental cues that trigger the behavior, and (4) examining the environmental consequences (rewards and aversive stimuli, schedules of reinforcements, etc.). They then establish specific goals based upon these data, and choose behavioral interventions (Bergan, 1977; Brown et al., 1987).

The Social Learning Model (SLM) of consultation (Brown et al., 1987) places more emphasis upon cognition than the strict behavioral model, and while they would use the same categories as the behaviorist, the content of the categories would vary somewhat: (1) define the cognitive behavioral and environmental components of the problem, (2) measure the incidence of the behaviors as well as the cognitions, (3) examine antecedent variables including environmental variables and cognitions, and (4) examine environmental as well as cognitive consequences of behavior.

It should be noted that while behavioral and SLM diagnostic procedures can be used with individuals, they can also be applied to groups. For example, it is possible to measure the incidence of lateness in a work setting and define its consequences for a whole group of workers. It is also possible to identify groups of consultees that have similar styles and needs and treat them as a group rather than as individuals.

Adlerian concepts have also been used to categorize client groups. Dreikurs (1968) identified the four mistaken goals of childhood as attention, power, revenge, and withdrawal. Teachers, parents, and child care workers can be taught to identify these mistaken goals and deal with them appropriately, either individually or in groups (Brown et al., 1979).

While behavioral, social learning, and Adlerian concepts can be used as the basis for assessing and categorizing client problems, so can any of the current psychological systems being taught and applied

in counseling or psychotherapy. These systems serve as a framework to guide the consulting process toward attaining these goals.

Which diagnostic system is best? There is no correct answer to this question. However, there are some criteria that should be applied in the selection process. First, the consultant should understand the system thoroughly and should be able to communicate it easily to the consultee. Second, the system should be such that it is acceptable by the consultee. Acceptance of a system by a consultee is dependent upon a number of factors. Teachers who have been taught humanistic theory reject behavioral systems. The more recent usage of cognitive-behavioral models has helped bridge the gap between person and behavior. The extensive record-keeping involved in measuring the client's behavior often becomes aversive for consultees, and this too can lead to rejection. As noted earlier, consultants need to be flexible enough to switch systems if it becomes apparent that the consultee is not accepting or understanding the one being used, or at least to modify it to suit the consultee (Bergan & Tombari, 1976).

The bottom line is that however the client's problems are categorized, the consultee and the consultant must have a set of common understandings and concepts from which to operate. It is this common ground that allows them to move forward effectively. Often, it is also the knowledge base gained in the diagnosis that is responsible for the consultee to feel confident and ready to become less dependent on the consultant.

The Consultee

Caplan (1970), in his consultee-centered model of consultation, suggests that consultee problems fall into four categories: lack of knowledge, lack of skill, lack of confidence, and lack of objectivity. Lack of objectivity occurs for a variety of reasons. One of these is simple identification, which results when consultees lose their objectivity because they perceive similarities between themselves and the client. A consultee who was once abused may identify too closely with an abused child. Transference is another basis for lack of objectivity according to Caplan (1970), and occurs whenever the consultee imposes a set of expectations upon the client. Characterological disorders also cause lack of objectivity and result because of personality deficiencies. Theme interference is the single largest cause of lack of objectivity, according to Caplan. A theme is an unresolved conflict which manifests itself repeatedly and is characterized by obviously faulty logic, such assertive that all children who make low grades are going to be failures in life.

Caplan (1970) believes that the majority of consultee problems would fall into his fourth category, lack of objectivity. This particular aspect of his classification system has been least accepted (Gallessich, 1982), perhaps because of its obvious psychoanalytic roots. While most consultants would agree that lack of objectivity may indeed

stem from some of the causes identified by Caplan, the authors would add three other bases for this problem, perceived threat to role competency, prejudice, and the overall inability to conceptualize problem, process, and consequence accurately.

Perceived threat to role competency is, according to Gross (1980), a normal reaction to a change process that may result in individual's losing status or impairing their ability to function on the job. The reaction of these perceptions is, quite naturally, resistance to the change process. This resistance can be allayed by assurances that role competency will actually be strengthened, although this reassurance may have to come from those with greater knowledge in some instances.

It is not unusual to see consultees who are biased against clients because of their ethnicity, race, religion, gender, SES, etc., and have this influence their objectivity. Whether this preconceived judgment stems from unresolved childhood conflicts or is simply the result of attitudes that are learned quite directly from the consultee's environment is a debatable issue. What is clear is that the prejudice, when it is present, must be dealt with if the consultation is to be successful.

Even though Caplan believed that most consultee problems will fall into the lack of objectivity category, it is becoming more clear that many consultees also lack skills, knowledge, incentive, and the conceptual understanding of the bigger issues and possible ways of correcting the problem. Consultants must learn to identify and deal with each type of problem, regardless of its incidence.

Diagnosing Consultee Problems

Lack of knowledge manifests itself in a number of ways and, at times, interacts with certain of Caplan's (1970) other categories. However, initially, for purposes of discussion, it will be treated as though it is independent of them.

Consultees often lack the formal knowledge needed to observe accurately, design programs, or initiate other types of action with clients. Deficits in theory, empirical data that pertain to the client, or common practices are not uncommon. However, lack of "local knowledge" such as organizational and community norms, the location of caregivers, and understanding of policies and procedures may also incapacitate a consultee. At times, a third deficit, lack of knowledge about the psychological and physical characteristics of the client may impede the consultee. The presence of a child with a learning disability may frustrate a teacher, just as a long-standing history of labor-management problems may impair an uninformed manager's ability to deal with employees.

A teacher may understand the theory involved in behavior modification, but not be equipped with the skills to translate the knowledge into classroom management procedures. Similarly, it is a

far cry between supervisory theory and implementing it in practice, just as counselors find that the things they read do not always translate directly into effective action.

Self-confident consultees can transfer their knowledge and skill into their practice, while those who lack self-confidence may not. Their self-doubt may result from an inability to practice what they have learned and to reject feedback from a lack of models, and the ability to reconceptualize issues, or just from a lack of support for their work (Bandura, 1977). Whatever its source, it results in an inability to act with clarity and assuredness.

In some instances, lack of objectivity is relatively easy to identify, but usually, it is not. Consultees who lack objectivity are, in a sense, irrational. They stereotype their clients. They think in black and white terms. They deny objective data that disconfirms their thinking, often faulting the data or the data collection. Suggestions or ideas from the consultant are met with yes-buts, and dismissed. Consultees may draw comparisons between themselves and the client or become overly emotional where the consultee is concerned (Caplan, 1970).

There are, of course, combinations of the above. Skills are often predicated in knowledge and self-confidence on understanding when and how to use a given skill. Lack of objectivity may have been at the root of the consultee's inability to develop either the knowledge base or the skills required to function in a particular area. Regardless of whether the problem stems from a single cause or multiple causes, the consultant and consultee must identify and agree upon the nature of the problem. Perhaps more importantly, the consultee must, ultimately, own the discrepancy.

Role Relationships: Determining Consultee's Problems

Collaboration between consultant and consultee was stressed in the diagnosis of the client's problems. Consultants are admonished to follow this same pattern in the diagnosis of the consultee's concerns. Throughout the process of determining the client's problems, the consultees should continuously be asked to examine their role in the problem and to identify reasons why they have been unable to correct the problem on their own. The consultant would, of course, take the lead in prompting this exploration by asking key questions (e.g., why do you suppose you overlooked that aspect of the problem? What do you need to know to understand the problem more fully? How would you handle this situation in the future?). But the consultant should not lead the way by diagnosing the consultee's problems and providing the diagnosis to them.

It should be recognized that an impasse can occur if consultee self-diagnosis is expected exclusively. Every consultant must be prepared to provide input to the consultees regarding the nature of their problems. This may begin by simple cueing and extend to the consultants' sharing their assessment of the consultees' difficulties. If

self-diagnosis does not succeed, and the consultee will not accept the consultant's assessment, consultants must be prepared to terminate consultation. This is particularly true if they conclude that the consultee's difficulty requires therapeutic intervention before consultation can be effective.

Goal Setting

Client Goals

The consultee in collaboration with the consultant should assume major responsibility for setting goals *with* the client, i.e., the problem becomes the goal, and together, the consultee and client change their focus from the past to the future. Consultees will initially look to the consultant to learn more about how to establish functional goals that the client will accept. Ultimately, the consultees should set their own goals, etc. The consultant's role is to assist the consultee to develop the skills to establish reasonable, attainable goals in concert with the client. It is also the consultee's responsibility to help avoid goal setting that involves the "fitting square pegs in round holes" phenomenon. Consultees often want clients to fit into their value system and initiate a change strategy without involving the client in the decision-making process. McClelland (1978), in summarizing his research on clients' motivation, states that unless the person to be changed understands and accepts the problem definition and the proposed solution, change is unlikely to occur. Consultants should not abdicate their ethical responsibility to the client by allowing this to happen.

Consultee Goals

Consultees should set their own goals, including the knowledge bases, skills, and changes they wish to make in themselves and their work. It is certainly appropriate for the consultant to offer direct suggestions regarding these goals or to engage the consultee regarding the appropriateness of the goals.

Characteristics of Goals

Perhaps the most important aspect of goal setting is making sure that you know when you have reached it (Carkhuff, 1983). This suggests that each goal should have a criterion attached to it. Attaining 95% attendance at a plant that has had an 85% rate is not only a worthwhile goal, but one that can be measured. We would know that you know when you have reached it. Reducing classroom disruptions (if disruptions is defined) to three per day in a out-of-control class would also be worthwhile and measurable.

A goal should also contain the time, space, expertise, material, or program by which the goal will be obtained. This involves strategy and intervention selection, which will be discussed in the next chapter. However, first, we determine *what* we want to do and define it in a

manner that will allow us to determine if we have, in fact, accomplished our goal. Then we determine *how* we will accomplish our goal.

Timelines for goal attainment must also be established. This is the "by *when*" of goal setting. Normally, goals also contain statements regarding the *who*, but in our case, we are talking about the client or consultee, so this becomes a bit superfluous. It must be admitted that all consultation goals, particularly those for consultees, will not, but should in fact, be stated as clearly as the who, what, where, and how format suggests. The fact that clients learn better, or workers are more satisfied, or that turnover has been reduced, or clients are being better served, is not indication enough that the consultee has achieved his or her goal.

Parsons and Meyers (1984) suggest that there is a bit more to goal setting than just specifying the how, what, when, where, and how many. They suggest that a broader perspective needs to be taken to include the environmental variables that impinge upon the behavior of the client. Their checklist for determining the adequacy of a goal includes:

1. Defining the goal in observable terms (the what) and the who.
2. Defining the goal so outcome can be counted.
3. Setting a direction for the goal change.
4. Describing the environmental conditions that accompany the behavior to be changed.
5. Gauge the impact of the change upon the environment.

Of these, numbers four and five deserve the most attention, since the first three are similar in nature to what has already been presented. Goals need to consider what environmental conditions accompany them, for these conditions may need to be altered before target behaviors will change. A family environment that is non-supportive of schoolwork creates a barrier to client change in this area. So does an unruly classroom. Widespread apathy in a mental health agency may need to be a target along with the specific behavior of a few employees. In fact, there may be a need to redefine (who or what?) the client.

Similarly, consultants often err by not anticipating the impact that changes in an individual or small group will make on other individuals in other parts of the organization (Brown et al., 1987; Kurpius, 1978, 1985). Consultants need to anticipate these changes and perhaps include them in their goal statements.

To illustrate this point, let us consider the teacher who, after consultation with a school counselor, decides to apply the Adlerian concept of logical consequences (i.e., matching punishment to the child's acts) in the discipline of one child who is typically late in returning from breaks. This teacher also expects to continue with more traditional disciplinary techniques with the other children, which

include completing extra assignments and being sent to the principal. The impact of changing the disciplinary procedures for one child on the others should not be underestimated. At best, complaints about the differential treatment by the children who are being disciplined in the traditional fashion are likely to occur. At worst, resentment and apathy may result.

Whether a consultant was involved in helping to establish the differential salary schedules paid to flight attendants and pilots that are used by some airlines is unknown. What is known is that even those attendants and pilots who had their job security enhanced as a result of the cuts, are now working with the unhappy new employees to have the wage system equalized. In short, anticipate the systemic effects of the goal, if attained, whether that system be a family, classroom, residence hall, or a major corporation, and establish goals accordingly.

Crisis and Consultation

A crisis situation may dictate that the collaborative approach suggested thus far be abandoned, and that the consultant move to an expert model where he/she takes charge of the diagnosis and goal setting, and prescribe the intervention. A crisis may also require that the consultant shift from Caplan's consultee-centered model to his client-centered approach, and meet with the client, render a diagnosis, and prescribe a course of action.

Bergan (1977) has provided a problem-centered interview procedure that can be used as a guideline for conducting a crisis-oriented consultation session.

I. Determine the behaviors and strengths of the behaviors of concern to the consultee
   - A. Gain information about client characteristics
   - B. Get a specific definition of problem
   - C. Get an indication of strength of problem
   - D. Reach agreement of definition and strength of behavior

II. Determine conditions under which behavior occurs
   - A. Establish antecedent conditions to client's behavior
   - B. Establish consequences of behavior
   - C. Examine sequence of behavior and specify time, place, etc.
   - D. Reach agreement on antecedents, consequences, and sequence of behaviors involved

III. Determine how client's behavior can be accurately assessed
   - A. Establish assessment procedure
   - B. Summarize and develop contract regarding assessment

IV. Establish time for next interview

Crisis situations require the consultant to engage in extraordinary consulting approaches that involve

momentarily focusing on the client and temporarily holding in abeyance the development of consultee skills and attitude. This posture should not be maintained once the crisis is past and the consultant and consultee should return to a collaborative model.

Summary

Problem identification requires that the consultant apply some framework for understanding human behavior to determine the who, what, when, where, and how many of the client's and consultee's problems. Generally, this process is a collaborative one, but in crisis situations the consultant may assume a more dominant role.

Chapter Four

Consultation Interventions

Interventions can be defined as actions or occurrences that alter a situation or a person's behavior. More specifically, Argyris (1970) defines intervention as entering into an ongoing system of relationships to come between or among persons, groups, or objects for the purpose of helping them. It can mean problem-solving, innovation, and/or facilitation in a collaborative relationship. The situation should improve as a result of intervention, and we can expect this improvement to come about through the assistance of the consultant who acts as a resource for helping. Ultimately, however, the consultee must act as the source of influence for change and assume ownership of the problem situation and its resolution.

Interventions must fit the nature of the problem (i.e., the problem may be public library patrons who are loud and disruptive, or it may be difficulty in mainstreaming a handicapped child in a classroom). Interventions must also fit the characteristics of the target population, which may be individuals, groups, or systems; such as individual students in an educational setting, groups of patients in a hospital ward, or a total school unit. The setting and context, referred to by O'Neill and Trickett (1982) as time, place, community traditions, and obstacles or opportunities of the environment, must be considered, as well as the culture and norms of the consultee or consultee system. These variables will greatly influence the consulting process and ultimately the choice and success of a given intervention.

Interventions are creative endeavors to help and should not be considered treatments to be pulled off the shelf and used at will. It is important to understand that accurate assessment, clear priorities,

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available resources, and agreed upon readiness are crucial for selections and implementing the best intervention for the consequences and outcome desired.

In a sense, *all* aspects of the consultation process can be construed as an intervention, whether it is entry, contracting, data collection, problem indentification, goal-setting, feedback or evaluation. Subtle interventions occur at every level of the process and throughout the consulting relationship (Beer, 1980; Boss, 1985). The initial interaction and communication between the consultant and the consultee or consultee organization can begin to impact and influence change through the consultant's questioning, modeling, imparting of information, and relationship-building. Even at the initial contact, when there is a sense of working toward problem and goal definition, consultees can experience a feeling of strength and support, based on the consultant's responsive skills of understanding, warmth, respect, and objectivity. For example, listening attentively to the issue being presented by the teacher and helping the teacher to clarify the present situation as well as the desired situation for a classroom of acting out children will foster greater awareness and understanding and a sense of being understood and appreciated by the consultant; thus enhancing movement toward problem refinement and subsequent resolution. It has been these very subtleties of the consultation process, the interactive consultation relationship, and the roles of the consultant and the consultee which have frequently caused difficulty in defining what consultation actually is and when intervention actually begins and ends.

Systems for classifying interventions

Interventions may be classified as remediation (Albee, as cited in Parsons & Meyers, 1984) or prevention. We are most familiar with remediation interventions (solving a problem that already exists), but preventive interventions are also carried out as in Caplan's (1970) model of consultation. Even before it was fashionable, Caplan viewed mental health consultation as a major force for prevention, beginning with caregivers such as teachers, nurses, counselors, and others who may directly and indirectly affect an entire population. We may also look at prevention in terms of whether it is primary, secondary, or tertiary.

Primary prevention strategies seek to promote growth in an entire community, school, or work organization. Rather than to remedy specific problems, the focus is on modification of elements in the environment, and the development of competence and adaptive efficacy, in order to prevent problems before they occur. This is accomplished by insight and visioning. Secondary prevention focuses on problems which are just beginning to appear; by intervening through early identification and subsequent intervention, the severity and impact of problems may be reduced. Tertiary prevention involves

assessment, diagnosis, and remediation in order to reduce the consequences of severe problems after they occur. In the sense that intervention strategies should be geared to enhance consultee growth, development, and the ability to solve future problems as well as benefit the immediate client(s); all interventions may be viewed as focusing on prevention as well as remediation.

Interventions may also be classified according to the size and complexity of the target group: individuals, dyads/triads, teams, intergroups, and total organizations (Bell, 1973). Or they may be classified as human responses to structural/technological demands (French and Bell, 1973), such as enhancing consultee's skills, knowledge, and/or changing beliefs and attitudes. In some cases, interventions are classified as responses to: (1) a particular problem or situation (e.g., child is disruptive in the classroom); (2) a diagnosed human, community or organizational need; (3) a specific target group, such as developmentally handicapped persons; or (4) the consultant's own values, theoretical orientation, and knowledge of intervention strategies and techniques.

Timing is important to effective intervention. Kurpius (1985) identified four developmental phases or change cycles that work groups typically experience. These phases are (1) *New Development stage*, the initial start up of a new program; in which excitement, creativity, and motivation may be high as well as the potential for conflict and disagreement about goals, processes, and roles; (2) *Maintenance Stage* occurs after development is completed and is a stage characterized by a sense of satisfaction with the way things are; (3) *Decline Stage* occurs when the members do not realize that growth and development will not occur unless they recycle to the development phase; usually resistance to improvement is such that self-directed recycling is difficult even though outside help is needed. If recycling does not happen, decline continues until a crisis is imminent; and (4) *Crisis Stage* occurs when all visible cues for requesting developmental help have been ignored and external forces for change are becoming apparent; i.e., the program is in danger of being discontinued, or people higher in the organization are requesting change. The human symptoms at stage four are denial, high stress, burnout, and inefficiency. Although these phases are common to all human and organizational systems, they may be applied to one's thinking about interventions with individuals and small groups as well. While consultants are sometimes used at the development phase, it is perhaps more common to be called in at the decline stage, when consultees recognize that outside assistance could be beneficial. Sometimes, however, consultees prolong asking for assistance until they are in such a state of crisis that they are unable to resolve the situation and all other consultee-generated interventions have been tried and have failed. For example, an idealistic young teacher may have great enthusiasm for her job in a school system known for its

rigidity and inflexibility; even though she may question goals, processes, and roles, she doesn't "rock the boat" and experiences satisfaction from her job. Eventually, however, she begins to realize that some outside help is needed to prevent maintenance and eventual stagnation; by the time consulting help is called upon, she is experiencing stress, burnout, and inefficiency. A similar situation could apply to residence hall staff or workers in a human service agency.

In another approach, Harrison (1970) classifies interventions by their depth, which refers to the degree of emotional involvement the individual or group has in the change process. Interventions which occur at very personal levels; i.e., those which deal with personal and private aspects of individuals and their relationships are "deep," while those which focus on roles and functions, tasks, resources, work performance, etc., are of less depth. Four Levels of intervention involvement are described: (1) concern with individual work style, communication, etc; (2) concern with interpersonal relationships, which focus on attitudes, feelings, and perceptions about one another; (3) evaluating and controlling individual performance; and (4) operational analysis of the roles and functions performed by the individual within the work group. Harrison had two recommendations important for choosing the proper intervention levels: (1) to intervene only at a level necessary to produce enduring solutions to problems; and (2) to intervene at a level no deeper than that which the energy and resources of the consultee or system can be committed to change. A group of nurses in a hospital setting may be open to intervention at the depth of communication, work style, performance, roles and functions to be performed by the individual within the group as in 1, 3, and 4 above, but interpersonal issues may make interventions at the depth of interpersonal relationships (2) very sensitive. The norms and culture of the nursing work group may inhibit interventions which focus on the deep level of interpersonal relationships rather than on the more superficial level of work-related issues.

Beer (1980) recommended a set of decision rules to help a consultant select and integrate various interventions, which can be summarized as follows: (1) Select interventions which make the best use of consultee or system resources; i.e., time, money, energy, skills, etc.; (2) interventions should be selected that best suit the consultee's or system's goals and needs; e.g., an intervention which trains teachers in behavior modification would be selected because student behavior in the school's classrooms is a major problem and improving it is an organizational goal; (3) select the intervention that will cause the least psychological strain in order to ensure individual and group consultee commitment and confidence in the intervention. Carl Weick has found that an intervention which may cause major change but with extreme stress is less likely to be successful than one which causes increments of change with lower levels of strain (Weick, 1985). For example, a hierarchical and abrupt implementation of a completely different

method of instruction for which teachers are little prepared and have no input will cause more conflict than gradual implementation of the same change.

Selecting and implementing interventions

Consultants should be guided in their choice of interventions by actively listening to the consultee, and helping the consultee to understand and conceptualize the meaning of the information that has been assembled. Discussions of potential interventions should only follow this period of clarification, allowing the consultant and consultee to detail the parameters of the problem and describe the desired outcomes. Research suggests that problem definition, problem ownership, and setting reasonable goals are the best predictors of the subsequent success of an intervention (Gibson and Fuqua, 1982; Kurpius, 1978, 1985). At the same time, however, the consultant may carry on an internal dialogue by mentally asking: What is the real problem here? Is it the same as the initial problem statement? What does the consultee really want from the consultant? Are there hidden agendas? Who will benefit/lose from a given intervention? Are my beliefs, skills, training and values congruent with the range of possible interventions needed? Do I fully understand the culture, norms, and values of this consultee and the consultee's organization? Will there be support from other parts of the system for any interventions which are implemented (i.e., if changes are implemented in classrooms, will the administration support the changes?) What will actually change as a result of the intervention? What can I do so we communicate our mutual concerns clearly?

The consultant will carefully consider the answers to these internal questions, while continuing a joint productive relationship with the consultee.

Consultee variables

As mentioned in Chapter three, the choice of intervention depends upon accurately diagnosing and classifying the consultee's and/or client's problem and need. In addition, there are a number of consultee characteristics which have importance for every level of the consultation process. These include consultee beliefs and values, a willingness to take risks, affect or emotional state, skill level and knowledge, and the commitment of the consultee in improving the situation through the consultation process.

It is important to determine the level of knowledge and skill of the consultee and to ascertain whether such possible limitations may be causing consultee resistance to a suggested intervention. For example, chairpersons unskilled in leading problem identification group discussions may appear to resist the suggestion of such an intervention, even though they and the consultant agree that better problem identification is a key variable in enhancing their role effectiveness.

The motivational level of the consultee is sometimes difficult to discern. However, freely sharing information, following through on collaboratively developed plans, and even such small behaviors as being punctual are indicators that consultees are personally invested and interested in the outcome of the consultation project.

Also important to the consultation process is the consultee's perception of the consultants influence. Implicit in the concept of "influence" is the concept of one individual having "power" over another. Power is described by French and Raven (1960) and others (Cobb, 1984; Kelly, 1983; Martin, 1978; Kurpius, 1986) as the potential of a person to affect the attitudes, behavior, or perceptions of another person; social influence is the successful application of that power. The consultant's age, personality, gender, assertiveness, credentials, and experience may all affect consultee's perceptions of social influence. French and Raven (1960) identify five forms of social power: (1) reward power, where one person has resources with which to reinforce desired behavior in another (as in the relationship between a boss and an employee); (2) coercive power, where an individual has physical, social, or psychological force over another in order to obtain the desired behavior change (as in the enforcement of law by police); (3) legitimate power, in which an individual is given legal, social or other recognized authority to direct the behavior of another (e.g., judges or political figures); (4) referent power, where an individual has personal and social qualities which lead others to identify with him or her and to model themselves after that person's behavior; and (5) expert power, in which an individual is a recognized, acknowledgeable authority in a specific area of expertise and whose advice is sought and usually taken. The last two types of power are likely to be influential in consultation relationships. A more broadly defined conceptualization of sources of influence are listed by Kurpius (1986), as competence, intimacy, expertness, attractiveness, trustworthiness, and power. The consultant is expected to be knowledgeable in specific areas which apply to human and organizational interactions, and should have the personal and social qualities which will enhance the likelihood that the consultee will accept the consultant as a person, as well as the consultant's behavior as a model.

Ethical considerations

The process of deciding upon and implementing intervention strategies will frequently be clouded by ethical issues (discussed at length in Chapter seven). We may be called upon to clarify (if only to ourselves) the values and beliefs we hold about people as unique individuals, and will need to clarify and consider our own motivation, decisions, and behaviors. We will need to continually check and revise them if we are to reach our full potential as competent, caring consultants. Benne, Bradford, Gibb, and Lippit (1975) and Robinson and Gross (1985) have listed "methodological values" which may help

help to clarify intervention decisions. These values include: (1) the process of helping should be open to empirical testing, aimed at continually revising and recycling, with reciprocal feedback; (2) interventions must be aimed at confronting tasks and situations, not toward maintaining or augmenting the personal prestige or status of the consultant or consultee; (3) helping processes should provide for self-evaluation, self-correction, and self-renewal of both consultant and consultee, with both open to revision of values, goals, and technique; and (4) efforts should be made to search for and make full use of all available relevant information and experience, with the consultant not necessarily an expert but a link to other resources.

Many unforeseen ethical issues arise in the implementation of interventions. Consultants may be forced to deal with beliefs that the action a consultee plans or suggests may be potentially harmful to the client(s). Consultants may feel a strong need to act as advocate when harm may occur to a target population. They may discover that the values of a consultee or the consultee's organization may be at odds with their own values. There may be hidden conflicts of interest, or the temptation to impose one's own beliefs or cultural norms on others. Consultants must face these issues with honesty, integrity, and authenticity if they are to foster their own growth and that of the consultee and consultee's client.

Resistance to change

Resistance to change is a fact of life for consultants, albeit a normal phenomenon. Consultees may resist change because they feel vulnerable, and may fear losing control or status. They may fear the "unknown." They may be unsure of their skills in implementing interventions, or may have a number of other anxieties. Block (1981) has listed some of the forms consultee resistance may take: (1) attacking the intervention plan as impractical; (2) acting confused; (3) refusing to talk about it; (4) intellectualizing; (5) being judgmental or moralizing; (6) being overly compliant (the familiar "passive-aggressive" response); (7) delaying implementation by asking the consultant for more details or stalling by offering unnecessary details ("yes, but..."); (8) being unable to set a time for implementation of the strategy (it's never quite the "right" time); (9) pressing for instant and easy solutions; (10) a "flight into health" (suddenly, the problem doesn't exist).

It's important for the consultant to recognize that resistance is taking place, and to understand the cause of the resistance. Such understanding will provide insight for the consultant to be better able to help the consultee continue to grow and develop in the relationship and in their current position. Sometimes resistance indicates that we've touched upon an important issue or problem; resistance may be a sign that you're on the right track. It is usually a reaction to anxiety, not a personal attack on the consultant; and is best dealt with by

increased emphasis on the collaborative relationship (Parsons & Meyers, 1984), and by supporting the consultee while continuing to move forward.

The role of theory in effective consultation

Hodges and Cooper (1983), in an article addressing the role of theories and models of consultation, have defined theories applicable to human interactions as "basic assumptions about the nature of people that lead to particular interventions, such as dynamic, humanistic, or behavioral" (p.29). Using this definition, the practice of consultation can be described as being based on humanistic, attribution, social-ecological, psychodynamic, social-learning, cognitive-behavioral, systems, and developmental theories, to name only a few. The consultation theories allow us a mode by which to deliver service in the wide varieties of classifications already mentioned. As Gallesich (1985) has pointed out, "psychologists typically carry their primary practices and the theories governing them into the consultation role" (p. 41).

To what extent should we base our interventions on underlying theories? Considerable discussion has been generated around the issue of "theories of consultation," with the consultation that no underlying theory exists which seems to cover all aspects of the consultation process.

Much of the literature on consultation is categorized in terms of major models: the mental health model of Caplan (1970), which includes elements of psychodynamic and humanistic theories; the behavioral model which includes social-earning and cognitive-behavioral theories (Bergan, 1977; Bandura, 1977, 1982; Russell, 1978; Vernberg & Repucci, 1986); and Organization Development models (Argyris, 1970; Schein, 1969; French, Bell, & Zawicki, 1983; Weisbord, 1978); which contain elements of systems theory (Havelock & Huberman, 1978; Short, 1985a, 1985b; Beer, 1980); humanistic-existential theories (Rogers, 1951); and social-ecological theories (Lewin, 1951; Aplin, 1978).

While models of consultation are not "pure" theoretically, they do tend to be theory-connected. Within these theoretical models, there is considerable overlap in terms of where, when, and how they are applied. For example, consultation to "mental health" or human service agencies may be exclusively based on Organization Development philosophy or behavioral theories, rather than Caplan's (1970) mental health model, and organizational consultants may find the need to include the use of behavioral or mental health consultation theories and interventions in a given organizational situation.

The very nature of the purpose of theories and models helps consultants to generate assumptions about the causes and solutions of presented problems, set goals, and select interventions. However, due to the limitations and overlap of the models outlined above, many

consultants will find an integrative approach more useful than a single model or theory-based approach. This is particularly true when consultants work in a variety of settings and situations.

In selecting an intervention, Hodges and Cooper (1983) noted that it is likely that everyone has either an implicit or explicit model of social change, which will help consultants to understand and explain why an intervention is chosen for a particular case. Without a thorough grounding in the theories of human interactions, thought, and behavior, a consultant may base intervention strategies upon vague and unfounded assumptions regarding what they believe to be useful and appropriate. Gallessich (1985) has pointed out that "consultation practices that are not based on and controlled by clear conceptualizations are likely to be harmful" (p. 344). The difficulties which may arise, according to Gallessich, may be due to an overemphasis on techniques. This may cause a faulty definition of the problem leading to choosing improper solutions.

Systems Considerations

All interventions must be considered in view of their impact on the total system in which clients or consultees work and learn. Systems are interdependent and may be defined as any set of two or more elements that interact in a pattern and in a stable manner over time. All systems contain smaller units or subsystems; and have boundaries, structure, function, and process. The system is both a source of influence upon its environment and is influenced by its environment (Havelock and Huberman, 1978). It actively interacts with its environment, and is homeostatic; i.e., strives to maintain the "status quo" within the system. Systems go through sequential and cyclical stages of development. A functional system is dynamic, cohesive, open to change, growth-oriented, and allows for "flow" in and out of the system, i.e., inputs and outputs. One of the chief characteristics of the "open" system is its continuous interaction within the system, as well as between the system and the outer environment.

As mentioned, an important attribute of systems is that they are made up of interdependent subparts and are interdependent with other, larger systems. Change in one part of the system will directly or indirectly produce change in another part. Thus, any changes which occur to individuals or groups as a result of consultation interventions will have an impact on other parts (individuals and/or groups) of the total system. Another point for consultants to remember is that each system is as unique as each individual within the system.

The systems implications for intervention strategies in consultation practice are obvious. For example, changing the rewards for individuals within the system will alter the functioning of the whole system. However, if individual behaviors only are changed without regard to the culture and values of the system, these behaviors are likely to be maintained only if the system for rewarding the new behavior is maintained. While changing systems variables may not be

possible in some situations, it has been found that if lasting change is desired, changing system variables has been a better predictor of intervention durability than focusing on human variables (Lewin, 1951; Aplin, 1987).

Overview of Intervention Options

The options presented here are intended to give only brief overview of available interventions. In following the title and purpose of this publication, interventions are presented in two categories: individual and group, as they apply to consultees and clients.

Interventions for working with an individual consultee

In keeping with the emphasis in this chapter on the importance of individuals within a system, the view of Fuqua and Newman (1985) is endorsed: although a systems-wide intervention is ideal, this may not always be possible or practical. Fuqua and Newman listed settings and situations when individual consultation is appropriate: (1) when the problems are strictly of an individual nature; (2) when system interventions are unlikely, impractical, or untimely; (3) when problem perceptions are limited to individuals; (4) when the consultee's work setting is highly resistant to change; (5) when individual behavioral change may be more efficient than system change because of the system's condition. If individual intervention is appropriate, these interventions may be focused on creating a working relationship; which would include communication, an adequate feedback system between consultant and consultee, collaboration and shared responsibilities. In addition, interventions can focus on the consultee's own behavior change, and on improving problem solving abilities and job performance. Within these broad areas, there are a large number of techniques, a few of which will be discussed here.

Cognitive problem solving - This intervention is based upon cognitive-behavioral theory, which considers thought processes, the mediating factor between the environment and a person's behavior. The technique involves aiding the consultee to identify a problem, generate alternative solutions to the problem, consider consequences of these solutions, choose the most desirable solution, and evaluate whether the solution was effective. Teaching, modeling and providing corrective feedback in the use of a step-by-step problem-solving strategy will give consultees more success and confidence in future situations where effective problem solving is necessary.

Modeling - Drawing primarily upon the work of Bandura (1977, 1982) and Meichenbaum (1977) in cognitive-behavioral and social learning theory, Brown and Schulte (1987) have identified modeling techniques that are aimed at increasing consultee and client self-efficacy and to promote skill development. A number of modeling techniques exist which will aid the consultee in learning how to respond to clients or co-workers in specific situations. Among them are *covert modeling*, in

which the consultee imagines and cognitively rehearses responses to a particular situation, or imagines a model performing a task which corresponds to a task the consultee will be required to perform. The consultee must think through and anticipate potential problems and consequences of actions. Kurpius and Morran (1988) have identified two types of covert modeling: covert self-modeling, in which consultees imagine themselves performing the behavior; and covert other-modeling, in which someone else serves as the model. *Cognitive modeling* is a technique in which a model thinks out loud about problem solutions. For example, a consultant may "walk through" a problem situation with the consultee, verbalizing the thought patterns required to conceptualize and deal with the problem effectively. *Vicarious* or *symbolic modeling* entails observing a live model modeling a desired behavior. Vicarious modeling may also occur via videotaped or filmed situations or through written material. For example, if consultees have difficulty acting assertively with a student in a classroom situation, they may watch a videotape of a work situation in which assertiveness is modeled, or may observe the consultant interacting and demonstrating the desired behavior. In *participant modeling*, the consultant demonstrates the desired behaviors, then asks the consultee to rehearse them, with the consultant providing coaching and corrective feedback.

Cognitive restructuring - Stone (1980); Ellis (1962); Kendall and Hollon (1981) and others have posited that maladaptive thinking in regard to situations or events leads to maladaptive emotional and behavioral responses. When consultees are faced with difficult situations, they may think "I must be perfect," or "my co-workers will think I am incompetent." The consultant's goal is to aid in identifying those cognitions which are maladaptive, and in developing more adaptive responses, such as "no one is right all the time."

Social reinforcers - Positive verbal statements, nods, smiles, or other verbal or non-verbal expressions of encourage are important behavioral techniques aimed at increasing and maintaining new consultee behaviors. As performance improvement continues, consultants will review positive cues from the environment which are reinforcement to the consultee and will provide positive assistance and feedback.

Training and development - In training and development, an assumption is made that knowledge and skill are lacking and that certain problems that occur in the setting will be solved if training is successful. Many such programs, workshops, seminars, etc., exist; which may include assessment skills, assertiveness training, stress management, or more specific work skills. The consultant would aid the consultee in discovering particular deficits and areas in which improvement is needed; and in many cases would assist the consultee in arranging for such training. (It will be obvious that training and development interventions may also apply to small groups).

Theme interference reduction - This intervention relies heavily upon the therapeutic skills of a consultant, although it must be emphasized that it is not therapy. It applies when a consultant believes that a consultee's difficulties in handling a client's case are related to his or her own past emotional experiences which prevent the consultee from viewing the client's difficulties objectively (Caplan, 1970). Based on these past experiences, a syllogism is formed by the consultee in which there is a link between the situation and an inevitable undesirable outcome. The syllogism takes the form "if A, then B" -the unsolved problem or situation in the consultee's past (A) inevitably leads to an expected negative outcome for the client (B). For example, a consultee may believe that all older sons in families are favored, since this is what happened in the consultee's own family. In Caplan's view, consultees tend to generalize these stereotyped expectations to all such situations.

The consultant uses such strategies as parables, in which the consultant relates a story similar to the problem situation which does not have the expected negative outcome; questioning the expected outcome in such a way that the consultee is led to doubt its inevitability; gentle confrontation; problem-solving; and modeling in order to persuade the consultee that the stereotyped negative outcomes of a client case are not inevitable. The consultant models objectivity by considering the facts of a client's problem realistically rather than emotionally. Focusing on the relationship between consultant and consultee produces a climate for non-defensive examination of the emotional attitude the consultee may have toward the client. Successful resolution of a problem case leads to improved functioning and a resolution of the underlying conflict.

Group Interventions

Group interventions may be effectively used when (1) economy and cost effectiveness are considerations and there is a need to make maximum use of consultant time and resources; (2) the target for change may be the system rather than a single client or consultee; (3) there is a need to improve communication, problem-solving, and cohesiveness among group members; and (4) the goal is prevention as well as remediation (Swift and Cooper, 1986).

Kurpius (1978) has proposed that interventions to small groups may occur as a result of the consultant assuming a *mediator* mode. In mediation, the consultant recognizes that a problem exists; then gathers, analyzes, and synthesizes information; decides on an appropriate intervention; and then calls together the group of persons (the consultees) who have direct contact with the problem and the greatest potential to influence a desired change. For example, a school consultant may recognize that a number of individual persons are involved in working with a child who has a behavior problem in school; with each individual independently treating the problem as

part of their role in the system. The consultant would then act as mediator to call together all individuals as a group in order to share the treatment proposal developed by the consultant. It can be a high-risk situation, since the child or children experiencing the problem are given priority, with less concern for bureaucracy, tradition, or hierarchical power within the system.

A major shift in the consultation field has been from individual, case-focused interventions to group and system-focused interventions. Organization Development, with its emphasis on the organization as well as the individual, clearly differs from the traditional mental health model of Caplan (1970) with its more individual focus. However, Goodstein (1972) indicates that successful individual interventions frequently lead to consultation regarding group and organizational concerns; and James, Kidder, Osberg, and Hunter (1986) note that Altrocchi, Spielberger, and Eisdorfer (1965) and Caplan (in Plog & Ahmed, 1977) included group interventions within the mental health model. Specific interventions for small groups will be discussed in this section.

Process consultation - One of the most universal group interventions is process consultation. Process consultation is aimed at helping people listen to each other in the language and beliefs of the presenter (Schein, 1969, 1978). The aim of intervention is to help the group (or individuals) to perceive, understand, and act upon events that occur in the group's or individual's environment; and to create changes in the beliefs, behaviors, and environmental forces that block efficient and effective accomplishment of tasks. The premise of process consultation is the assumption that the best way to arrive at a workable solution which consultees will accept and implement is to involve them in the total process of diagnosing a problem and generating a solution. The focus is not on providing specific content but to engage the group in a problem-solving process by which the problem and solution are defined and owned by the group.

Team building/group development - These interventions have the common goal of helping group members to identify and modify barriers to effective group effort. Group development involves members in the process of developing work-related individual and group goals in relation to goals of the work organization (French & Hollmann, 1975; Kurpius, 1982). Group development is primarily task-oriented, and should be used to clarify task issues such as goals, objectives, priorities, roles, and desired outcomes. It is similar to process consultation in that it can help group members conceptualize, define, and solve problems, but it has the added dimension of developing the group so they can continue to work together in the future.

Team building differs from group development in that it emphasizes personal sharing in order to achieve team cohesiveness. Subgoals are: a better understanding of each person's role in the work group;

increased communication among members about issues that may affect the group's efficiency; increased support among group members; learning more effective problem-solving at both task and interpersonal levels; collaboration among group members and less competition; learning to use conflict in positive rather than destructive ways; improve ability to work with other work groups in the organization; and a sense of interdependence among group members. To accomplish these goals, group members may be expected to exchange perceptions of each other in relation to the work situation. Kurpius (1985) points out that "it should be made quite clear to members that part of the process will require talking to each other about each other" (p. 379). The aim of team-building is a more cohesive, mutually supportive, and trusting group with a mutual work-related task to accomplish; which, at the same time, respects individual differences.

Consultants may use a variety of strategies to foster this personal sharing. Reilly and Jones (1974) have given some examples of process interventions to heighten the team's task accomplishment. These include: inviting the group to develop action plans related to a problem solution; suggesting that the group summarize what has been covered within a given period; using instruments, questionnaires, and ratings to assess the group's position on a particular topic; and having the group translate an issue into a problem statement, then a goal statement. Process interventions aimed at group building and group maintenance include: pointing out dysfunctional behaviors which keep the group from achieving cohesiveness; encouraging group members to express feelings about decisions made by the group; confronting behaviors that lead to defensiveness and distrust among group members; and encouraging group members to respond to one another's ideas and opinions verbally. Questionnaires, simulated games and exercises, and structured experiences may be used to help the team develop a better understanding of its own process.

Conflict resolution - Conflict resolution refers to bringing together two parties (groups or individuals) who are experiencing differences due to miscommunication, role conflicts, competition, value differences, external pressures, or other causes. The goals are for each party to articulate, understand, and resolve their conflict if possible. Robert (1983) has defined the role of the consultant as that of facilitator and impartial mediator in order to manage the dispute in the best interests of group productivity; and as teacher/trainer to teach clients to become effective in handling their own conflicts. Fisher and Urey (1981) defined the tasks of the consultant in conflict resolution as: (1) to define the problem without bargaining over positions; (2) to separate the people from the problem; (3) to focus on interests, not positions or roles; (4) to invent options for mutual aim of all parties concerned; and (5) to insist upon objectivity.

Training and Development - Training groups in specific skills, new

developments, knowledge, etc. may be a cost-effective intervention if specific skill and/or knowledge deficits are identified in a work group. The list of specific types of training, as mentioned earlier, is endless. The consultant may be instrumental in identifying training needs; and, in some cases, may act as teacher or trainer.

Quality Circles - Quality circles are still popular today, although receiving less publicity. They are usually small (3-15 employees) problem-solving groups which allow workers some autonomy in making decisions in the work place. Quality circles have been widely used in Japanese industry to improve communications and commitment among employees. Quality circles may meet weekly but should not meet less than twice monthly. Meetings are on company time and about one hour per session. A fundamental assumption supporting quality circles is that grouping workers together enhances their ability to identify and resolve problems. Ferris and Wagner (1985) note that American quality circles have often included training in techniques such as data gathering, use of control charts, and other work techniques aimed at fostering worker understanding of organizational problems such as cost reduction, pollution control, improvement of employee morale and improvement in overall work satisfaction and employee efficiency (Barra, 1983; Sasaki and Hutchins, 1984).

Cognitive-behavioral interventions - Many of the interventions stated in individual cognitive-behavioral models of intervention are also suited to working with small groups. For example, modeling, cognitive problem-solving; and cognitive restructuring could be presented in a group setting. A small group of employees may participate in a structured problem-solving group, or they may watch a videotaped demonstration of how to handle a disruptive public library patron.

Organization Development Intervention - Organization Development is a process that grew out of the humanistic theories of Lewin (1951), Rogers (1951), Maslow (1954), and others; and has been further articulated by Argyris (170), Schein (1969), Bennis (1966), Lippit (1971), Block (1981), Schmuch (1982) and others. The goals of Organization Development (OD) are to improve efficiency, work skills, interpersonal skills, and the quality of work life and job satisfaction for individuals and groups. Goals may be immediate and aimed at remediation of problems, as well as preventive and long-term, aimed at continuing development of the human and structural components of the organization or group. It is intended to aid individuals and small groups within an organization, as well as the organization itself, to achieve full potential. Many of the interventions previously discussed; e.g., conflict resolution, training and development, team building and group development, quality circles, and process consultation, have their roots in OD. Organization Development considers change within the framework of the total system. Interventions in OD may also be structural; in which the work environment, job assignments, job scheduling, etc. may be altered in order to increase efficiency and

work satisfaction. As mentioned earlier, interventions which change system variables may be more durable and lasting than those focusing on human variables.

Summary

A variety of variables must be considered in the choice of interventions. These include the size and complexity of target groups, whether the consultee is an individual, group, or organization; the timing and depth of intervention, the nature of the problem; the characteristics of the committee(s) or consultee organization and the target population; ethical considerations; the role of theory and models; systems considerations; the knowledge, skills, beliefs, and values of the consultant; and whether the intervention is aimed at remediation or prevention, or both. It can be easily seen that it is difficult to neatly categorize interventions under appropriate headings in a discipline which has, by definition, such a broad base that encompasses individuals, groups, organizations, and communities with a diversity of problems, for which a wide variety of interventions can be chosen. There are overlapping strategies within each model and between models, as well as differences in agreement on the meaning of a given intervention. We have not attempted to be comprehensive in our overview, but only to give a flavor of the variety of interventions which can be used.

Chapter 5

Evaluation of Consultation

Evaluation is a term which is often used by consultants but is frequently avoided or planned for in a haphazard fashion. This is partially the case because evaluation is confused with research, and research is not valued by many practitioners. Research is aimed at predicting an outcome or explanation among or between two or more variables. Investigations under the rubric of research may be designed to simply add to our knowledge base in a particular field or to support a theory (Pfeiffer & Olson, 1981). Evaluation is a systematic, objective way of determining the effectiveness and limitations of the consultant's intervention(s). While research results may have implications for a variety of individuals in many different settings, evaluation centers on an individual setting, consultee, and client system (Gallessich, 1982). The data gathered from a sound evaluation can provide relevant information about the consultant's role, consultee changes, and responses in the target population. As data are reviewed appropriate decisions can be made regarding continuation of services, alternative interventions, bringing on an additional resource person, or that satisfactory progress is being obtained toward problem resolution. For the consultant, evaluation can help hone intervention skills and identify current or future trouble spots in the consultation.

In chapter 2 preconsultation tasks were discussed. Clearly, evaluation warrants attention at the time of initial contact with the consultee. At a minimum, during this early phase the consultee should be aware that evaluation is a significant component of the process and will be addressed in more detail once the problem is identified and intervention strategies selected. The central point here is to involve the consultee in as many aspects of the evaluation process as possible so that the intent and utility of the effort is understood and supported.

Extensive Designs

As suggested earlier, evaluation may focus on the consultant, consultee, or target group. Trying to decide whether to evaluate in all three areas may be related to the individual or organization's financial resources as well as the consultant's skill in the evaluation process (Caplan, 1970). Extensive designs, one method of evaluation, rely on what is commonly understood as the experimental method. The experimental method is predicated on randomly assigning a small number of members (5-7) of a much larger target population to two groups: experimental and control. The control group serves as a comparison for interventions with the experimental group and does not participate in the consulting process. Typically, both groups are measured before and after the intervention to determine if changes in particular behaviors or attitudes have occurred. Assuming that changes in the experimental group are evident, one logically concludes that these changes were a result of the consultant's intervention. Concomitantly, the consultant may also infer that a similar intervention may be as effective with other members of the population if the sample in the experimental group is representative. For example, if an employer noticed improved employee performance after exercising an option to choose a flextime schedule over a standard 8:00 a.m. to 5:00 p.m. schedule, we could conclude that changes in performance were a result of the choice provided. Though this example sounds rather uncomplicated, evaluation designs of this kind can become quite complex and difficult to execute. In fact, many writers (Brown et al. 1979; Caplan, 1970) have questioned the value of extensive designs and favor an approach to evaluation that considers the processes and outcomes of a particular consultation effort. The later design is called the intensive or case-study method (Brown et al., 1979). Intensive evaluation designs are specifically tailored to concretely identify what changes have taken place in the target population during the time of the consultative effort.

Intensive Designs

These designs may differ based on the focus of the consultant's work, but several essential features are common to this approach. Again, the consultant should carefully discuss evaluation strategies and procedures at the earliest possible date to assure the consultee's involvement and cooperation. Gallessich (1982) provided a framework for the kind of data required:

- The degree to which the desired goals were reached.
- The factors that contributed to both positive and negative outcomes.
- Interim feedback about how an intervention is progressing.
- The cost/benefit ratio of interventions.

- The consultant's overall effectiveness in the various stages and processes of consultation, such as contracting and diagnosis. (p. 338)

The comprehensive evaluation model, emanating from this framework, is also described by Gallessich (1982) and includes the following components:

Targets of the intervention: The general rule applied by many consultants to the selection of a goal for the intervention is, "the more specific, the better." The consultant and consultee agree on behavior(s) they wish to change in a target population and proceed to collect baseline data for comparison at the end of the intervention. Additional pre- and posttest measures are agreed upon and employed if applicable. For example, targeted behaviors may include a reduction in the number of racial incidents on a campus or a decline in the frequency of reported thefts in an industrial complex. Other interventions may concentrate on attitudes toward work and require the administration of a questionnaire before and subsequent to the intervention.

Intervention inputs: It is important that the kind and quality of assistance provided to the consultant as well as the kind of services offered by the consultant be evaluated. Secretarial, technical, and other support services should be considered as well as the role played by the consultant (e.g., mediator, advisor, staff trainer, or small group activity leader) upon the outcome of consultation.

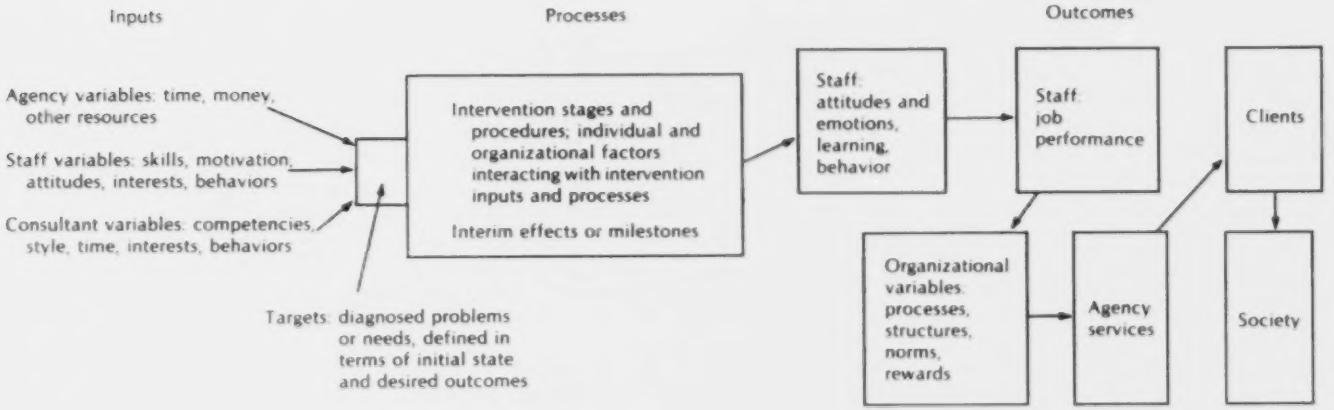
Processes: Many events or circumstances can impact on an intervention. Unannounced layoffs, illnesses, or large unsolicited donations to an organization are a few examples that can dramatically influence the success or failure of a particular intervention. These need to be documented.

Outcomes: Outcomes may be expressed in terms of benefits to the consultees or to the clients. For example, if the consultant's intervention with teachers is designed to reduce the acting out behavior of school children, we are also likely to see an increase in teacher morale if the consultation is effective. As teacher morale improves we may also see greater teacher participation in other local activities from which the entire community benefits. See Figure 3 for a graphic representation of the model.

The A Design

This design simply means the collection of observable data regarding a target behavior (Bergan, 1977). It is baseline data that the consultant and consultee can later use to determine the outcome of the consultant's intervention. Brown et al. (1979) suggested that the most effective way to collect these data is to employ a time sampling procedure. The time sampling procedure not only recognizes the importance of recording the frequency of behavior within a specified time period but also places value on observations during segments of the time frame. A consultant may ask a school principal to record the

Figure 3. A systems model for evaluation of consultation. From *The Profession and Practice of Consultation* (p. 340) by J. Gallessich, 1982, San Francisco: Jossey-Bass.


Inputs
Processes
Outcomes
Agency variables: time, money, other resources
Staff variables: skills, motivation, attitudes, interests, behaviors
Consultant variables: competencies, style, time, interests, behaviors
Targets: diagnosed problems or needs, defined in terms of initial state and desired outcomes
Intervention stages and procedures; individual and organizational factors interacting with intervention inputs and processes
Interim effects or milestones
Staff: attitudes and emotions, learning, behavior
Staff: job performance
Clients
Organizational variables: processes, structures, norms, rewards
Agency services
Society

From *The Profession and Practice of Consultation* (p. 340) by J. Gallessich, 1982, San Francisco: Jossey-Bass. Reprinted By permission of the publisher.

time of day (early morning, late morning, or afternoon) that suspensions are most frequent. It is essential that this information be as accurate as possible so the consultant and consultee may want to consider the advisability of using trained observers and recorders if appropriate for the problem and evaluation scheme.

AB Design

This design builds on the A design but adds the consultant's intervention (B). The AB design is also called the basic time-series design (Glass, Wilson, & Gottman, 1975) and requires data collection over the course of the consultation. Using this format it is easy to judge intervention effectiveness and modifications as required. See Figure 4 for a summary of time-series designs.

Figure 4. Time-series designs. The letter O stands for observation of behavior; The letter I stands for intervention; C stands for criterion; subscripts indicate different interventions or criteria.

Single-Group Designs				Multiple-Group Designs			
AB				Multiple-Group, Single-Intervention			
OOO	I_1OOO			Group 1	OOO	I_1OOO	
				Group 2	OOO	I_1OOO	
ABAB				Group 3	OOO	I_1OOO	
OOO	$I_1O I_1O I_1O$	OOO	$I_1O I_1O I_1O$				
Single-Group, Multiple-Intervention				Multiple Baseline across Groups			
OOO	I_1OOO	I_2OOO		Group 1	OOO	I_1OOO	I_1OOO OOO
				Group 2	OOO	OOO	OOO OOO
Interaction				Group 3	OOO	OOO	OOO I_1OOO
OOO	I_1OOO	I_2OOO	I_1I_2OOO				
				Multiple-Group, Multiple-Intervention			
Multiple Baseline across Behaviors				Group 1	OOO	I_1OOO	
Behavior 1	OOO	I_1OOO	OOO OOO	Group 2	OOO	I_2OOO	
Behavior 2	OOO	OOO	I_2OOO OOO	Group 3	OOO	I_1OOO	
Behavior 3	OOO	OOO	OOO I_1OOO				
				Reversal			
Multiple Baseline across Situations				Group 1	OOO	I_1OOO	I_2OOO
Situation 1	OOO	I_1OOO	OOO OOO	Group 2	OOO	I_2OOO	I_1OOO
Situation 2	OOO	OOO	I_1OOO OOO				
Situation 3	OOO	OOO	OOO I_1OOO	Stratified ABAB			
				Type A Group			
Changing Criterion				OOO	$I_1O I_1O I_1O$	OOO	$I_1O I_1O I_1O$
OOO	I_1C_1OOO	I_1C_2OOO	I_1C_1OOO	Type B Group			
				OOO	$I_1O I_1O I_1O$	OOO	$I_1O I_1O I_1O$
				Type C Group			
				OOO	$I_1O I_1O I_1O$	OOO	$I_1O I_1O I_1O$

From *Behavioral Consultation* (p. 170) by J. R. Bergan, 1977, Columbus, OH: Merrill. Reprinted by permission of the author.

ABC Design

This design allows the consultant to readjust an intervention or add a different strategy after the consultation process has begun. For example, an intervention may require that a teacher close the door (B) as soon as the bell rings to reduce tardiness. If this plan is not as effective as desired the consultant may ask the teacher to also begin lecturing (C) as soon after the door is shut as possible. The problem typically associated with this design is the difficulty in determining which intervention is responsible for the change in behavior. The change could be due to some carryover effect from the first intervention or solely the result of the second intervention.

Other Designs

A variety of additional designs exist for the practitioner and include reversal, multiple comparison across behaviors, individuals, and situations (Bergan, 1977; Brown et al., 1979; Glass et al., 1975; Stufflebeam, 1971). The reader is directed to one of the above mentioned sources for a more detailed assessment of these designs.

Some Useful Instruments

Since there are only a small number of instruments available with which consultation can be evaluated, Brown et al. (1987) pointed to the need for continuing improvement in this area. However, consultants may choose to use a standardized questionnaire or survey instrument from the limited number available or they may also develop one that especially suits their purposes.

Gallessich (1982) also discusses the possible use of organizational records, interviews, and observations in the evaluation process. Brown et al. (1987) also suggested that the consultant consider the match between instrumentation and purpose of the study as well as the consultant's theoretical orientation. No matter what approach or approaches are utilized to collect this information, the consultant needs to consider cost and time factors as important determinants.

The following three instruments are examples of the kind of measures the consultant might use in the consultation process and are self-explanatory.

Evaluation of Consultants

More attention has been devoted to evaluating the consultee and changes in target behaviors of clients than the consultant. Although if the client and consultee are unaffected, the consultant is probably ineffective. However, emphasis needs to be placed on the evaluation of the consultant because this can provide a rich opportunity to enhance the consultant's expertise and improve services to consultees and clients. Some consultants and consultees will prefer an evaluation format which will provide feedback after each session. This approach

allows the consultant to make changes in strategy as the intervention is in progress. Others will prefer a one time only evaluation of the consultant which would follow the concluding consultation period.

Ideally, the consultant would receive structured feedback during the course of the consultation as well as a culminating assessment. This will allow for (1) modifications in the session by session plan, (2) an opportunity to correct problems as they occur, and (3) an overall evaluation of one's performance.

Methods

Consultants have used a variety of ways to generate information about their performance (Alpert & Associates, 1982; Brown, 1987; Gallessich, 1982).

Gallessich (1982), for example, has suggested that the open-ended interview is perhaps the most effective method for collecting data regarding the consultant. In lieu of individual meetings, she supports small group meetings with consultees in large organizations. Questionnaires and surveys have also been developed to assist in this important procedure (Gallessich, 1982). See Figure 8 for another example of the kind of instrument currently available. Some general questionnaires, such as the one shown here, can be used as is while others will require slight modifications to match particular consultees' and consultants' interests.

Although cost and/or access may be a problem, videotaping and audiotaping can also be employed by the consultant as an additional method of enhancing professional development in this field.

Summary

Evaluation is a structured procedure used to assist the consultant in understanding the impact of interventions designed specifically for the consultee. Information from the evaluation can also indicate whether an intervention should be modified, or simply dropped in favor of a different strategy. Some instruments are available to help guide the consultant's data collection.

We recommend discussing evaluation with consultees as early in the process as possible to gain consultee support. Extensive and intensive designs have been considered as the major approaches to evaluations led by consultants. Although extensive designs may allow generalizations to other settings, intensive designs are more valued for their ability to give setting specific feedback to the consultant and consultee.

Evaluations can be a great asset to the consultant and consultee if carefully planned and conducted.

Figure 5. Consultation Preference Scale

INSTRUCTIONS Assume you will be consulting with a _____ concerning a _____. Below are twenty five statements relating to your consultation. Please rate each statement by circling the number below it which best indicates your agreement with its content.

Code	*Item*				
C1	1. The goal of the consultant should be to work with me to identify the problem, to plan and to carry out recommendations.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
C2	2. The consultant and I should both identify the problem based on information we have collected.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
MH3	3. I should plan the recommendations with the consultant offering suggestions.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
CL4	4. I should implement the recommendations that the consultant has developed.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
MH5	5. Further consultation should be initiated only at my request.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
E1	6. The goal of the consultant should be to plan and carry out recommendations after I have identified the problem.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
CL2	7. The consultant should identify the problem based on information he or she collects.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
E3	8. The consultant should plan the recommendations which he or she will then implement.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
C4	9. The consultant and I may each implement some of the recommendations.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
CL5	10. It should be the role of the consultant to offer me any further advice.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree

Code	Item				
CL1	11. The goal of the consultant should be to identify the problem and develop recommendations that I will then carry out.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
E2	12. I should be the one to identify the problem based on the information I collect.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
C3	13. The consultant and I should both suggest recommendations that we will both then implement.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
CL4	14. I should be the one to implement the recommendations that I develop.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
E5	15. There should probably be no follow-up consultation after the recommendations have been implemented.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
MH1	16. The goal of the consultant should be to increase my ability to deal with similar problems in the future.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
MH2	17. The consultant should help me identify the problem by clarifying my perceptions of it.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
CL3	18. The consultant should suggest recommendations that I will then implement.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
E4	19. The consultant should implement the recommendations that he or she develops.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree
C5	20. The consultant and I should engage in continuous follow-up to modify the intervention recommendations, if necessary.				
	1	2	3	4	5
	strongly disagree	disagree	neutral	agree	strongly agree

From "Models of Consultation" by N. Babcock and W. Pryzwansky, from the *Journal of School Psychology*, (1983) 21, pp. 359-366.
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Figure 6. Consultation behavior for categories and criteria. From *Psychological Consultation: Introduction to Theory and Practice* (pp. 251-257) by D. Brown, W.B. Pryzwansky, and A.C. Schulte, Boston: Allyn and Bacon. Reprinted by permission of the publisher.

Consultation Behavior Categories and Criteria

I. Consultee Information-Reporting Behaviors

1. *Quantity of information reported:* This category allows the consultant to focus on the extensiveness of the teacher's available fund of observations. The following behavior criteria are used in detailing observations:
   - 1a. The teacher reports a limited amount of information, narrow in range, and restricted to a few aspects of the problem.
   - 1b. The teacher reports a wide range of information about many different aspects of the problem.
   - 1c. The teacher reports an extensive amount of information about a few aspects of the problem.
   - 1d. The teacher has used several sources of information to collect data about the problem.
2. *Quality of information reported:* This category refers to differences in the quality of information reported by teachers. The following criteria are used:
   - 2a. The teacher's information is specific.
   - 2b. The teacher's information is vague.
   - 2c. The teahcer's information is detailed.
   - 2d. The teacher's information is general.
   - 2e. The teacher primarily reports information obtained from observation of the external environment.
   - 2f. The teacher primarily reports information obtained from observations of his/her own feelings, thoughts, and personal reactions to the problem situation.
   - 2g. The teacher's information is selective and organized according to some personal hierarchy of relative importance.
   - 2h. The teacher's information is unorganized and does not reflect the use of any personal hierarchy of relative importance.
   - 2i. In response to consultant questions or comments, the teacher voluntarily offers primarily negative information about the problem situation.
   - 2j. In response to consultant questions or comments, the teacher voluntarily offers primarily positive information about the problem.
   - 2k. In response to consultant questions or comments, the teacher voluntarily offers both negative and positive information about the problem.
   - 2l. In response to consultant questions or comments, the teacher does not volunteer additional positive or negative information.

II. Consultee Resistance-Cooperation Behaviors

3. *Extent of Participation in Problem-Solving:* This category refers to the extent to which the teacher displays a willingness to cooperate as an equal status problem-solving partner during the consultation interview and the degree to which the teacher exhibits commitment to problem-solving activities.
   - 3a. The teacher limits responses to answering the specific question asked.
   - 3b. The teacher answers questions and voluntarily elaborates broadening the range of problem solving.
   - 3c. The teacher asks questions or requests information about the problem.
   - 3d. The teacher does not actively seek clarifying information about the problem.
   - 3e. The teacher avoids certain problem-solving activities.
   - 3f. The teacher engages in all three problem-solving activities.
   - 3g. The teacher demonstrates receptivity toward recommendations offered.
   - 3h. The teacher rejects or refuses recommendations offered.
   - 3i. The teacher restricts feedback about recommendations offered.

4. *Maintenance of the Interview Focus*: This category refers to those teacher verbal behaviors which either facilitiate, impede, or have neutral effects on the consultant's attempts to structure the interview in an orderly sequence and maintain a problem-centered focus.
   - 4a. Teacher responses to consultant questions or comments are relevant to the focus of the problem-solving discussion and enhance the orderly progression of the interview.
   - 4b. Teacher responses to consultant questions or comments are relevant to the focus of the problem-solving discussion but do not enhance the progression of the interview.
   - 4c. Teacher responses to consultant questions or comments are irrelevant or tangential to the focus of the problem-solving discussion and impede the orderly progression of the interview.
   - 4d. The teacher answers consultant questions but in so doing changes the focus of the interview.
   - 4e. The teacher answers consultant questions but maintains the focus of the interview.
   - 4f. The teacher interrupts problem-solving activities to discuss his/her own personal and/or professional concerns, changing the problem-centered focus of the interview.
   - 4g. The teacher sustains problem-solving activities and introduces additional personal and/or professional concerns at appropriate intervals without changing the problem-centered focus of the interview.
   - 4h. Consultant questions or comments elicit the teacher's negative affective involvement (in varying degrees of intensity) with the problem, which disrupts the maintenance of a problem-centered focus.
   - 4i. Consultant questions or comments elicit the teacher's positive affective involvement (in varying degrees of intensity), which maintain the problem-centered focus.
   - 4j. Consultant questions or comments elicit the teacher's neutral affective involvement, which maintains the problem-centered focus.
5. *Consultee Influence Attempts*: This category refers to those verbal behaviors which reflect the teacher's attempts to actively influence the consultant's perceptions of the problem situation in a positive or negative direction. They thus reflect the way in which teachers use information available to exert influence over the consultant's perceptions or interview behavior. It should be noted that four of the criteria presented under this category (5 g; 5 h; 5 i; 5 j) were also used to delineate certain consultant information-reporting behaviors (2 i; 2 j; 2 k; 2 l). They are included here because they also allow the consultant to observe how a specific type of information may be used by the teacher to facilitate or impede problem-solving efforts.
   - 5a. From the outset of the problem-solving interview, the teacher offers a diagnosis and solution that limit any further exploratory problem-solving activities.
   - 5b. The teacher suspends judgment about the diagnosis and solution and engages in exploratory problem-solving efforts.
   - 5c. The teacher seeks confirmation of the validity of his/her perceptions of the problem situation.
   - 5d. The teacher adheres to his/her perception of the problem situation despite the introduction of alternative explanations.
   - 5e. The teacher is receptive to additional information or alternative explanations and considers them within the framework of his/her professional experience.
   - 5f. The teacher does not clearly articulate his or her perceptions of the problem and both seeks and willingly accepts the consultant's "expert" interpretation.
   - 5g. In response to questions or comments, the teacher voluntarily offers negative information about the problem situation.

5h. In response to consultant questions or comments, the teacher voluntarily offers primarily positive information about the problem.

5i. In response to consultant questions or comments, the teacher voluntarily offers both negative and positive information about the problem.

5j. In response to consultant questions or comments, the teacher does not volunteer additional positive or negative information.

5k. In response to consultant questions, the teacher introduces additional information not sought by the consultant and irrelevant to the discussion in progress.

5l. In response to consultant questions, the teacher introduces additional information not sought by the consultant and relevant to the discussion in progress.

Figure 7. Formative Evaluation Checklist

Directions: For each stage of the consultation process, feedback and request for corrective feedback from institutional representatives and consultees are both appropriate and desirable. The checklist provides a broad framework from which to conceptualize the specific formative function to be used within your particular consultation relationship.

Name of Institution _____ Name of Consultee _____ Date of Initial Contact _____

	Consultation Stage				
Formative Issue	Entry	Goal Identification	Goal Definition	Intervention	Assessment
1. Records of contacts (record dates, length of sessions)					
2. Special focus of contacts; concerns emerging for later consideration					
3. Provide feedback to highest relevant administrator (acceptable direction, time line, cost tone)					
4. Request feedback from consultee: Expectations met? Specific concerns? New needs? Suggestions for modification of program? Consultant style?					

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Formative Issue	Consultation Stage				
	Entry	Goal Identification	Goal Definition	Intervention	Assessment
Or administrative details (meeting times, rooms, and so on)					
5. Stage-specific concerns	All relevant personnel contacted? Collaborative atmosphere? Relationship skills?	Agreement on level of entry? Optimal entry point? Possible recontact?	Consultee's skill, cooperation, facility in data gathering/ reporting? Data complete?	Feedback to consultee on joint ownership? Consultee accept? Agree? Understand? Modifications? Joint agreement?	Outcomes? Inputs? Process? Design? Decision Options? Assessment as collaborative effort?
6. Counselor's perception of process to date—new paths tried					

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Figure 8. Consultation Evaluation Survey

Consultation Evaluation Survey

Your organization _____ Date _____

Consultant's name _____

Number of years you have worked in this type of organization _____

Sex (circle one): Male Female

Have you had previous experience with consultants?

Yes No

To what extent have you made use of the consultant this year?

____ Not at all

____ Very little, 1 or 2 times

____ To a moderate extent, about 3 to 6 times

____ To a considerable extent, about 6 to 10 times

____ To a great extent, more than 10 times

In general, how helpful has the consultant been to you? (Circle the number that is most descriptive)

Not at all 1 2 3 4 5 6 7 Very helpful

Did you work with the consultant in a group situation?

Yes No

Did you work with the consultant on an individual basis?

Yes No

Please respond to the following items by circling the number that best describes your perception of your consultant. Response options range from 1 (not at all descriptive) to 7 (very descriptive). If an item does not seem applicable to your consultant, circle N A.

The consultant:

1. Offers useful information	1	2	3	4	5	6	7	N A
2. Understands my working environment	1	2	3	4	5	6	7	N A
3. Presses his/her ideas and solutions	1	2	3	4	5	6	7	N A
4. Is skilled in forming good working relationships	1	2	3	4	5	6	7	N A
5. Is a good listener	1	2	3	4	5	6	7	N A
6. Helps me find alternative solutions to problems	1	2	3	4	5	6	7	N A
7. Increases my self-confidence	1	2	3	4	5	6	7	N A
8. Helps me identify resources to use in problem solving	1	2	3	4	5	6	7	N A
9. Is not concerned with my point of view	1	2	3	4	5	6	7	N A
10. Encourages me to make my own decisions	1	2	3	4	5	6	7	N A
11. Helps me find ways to apply content of our discussions to specific situations	1	2	3	4	5	6	7	N A
12. Respects values that are different from his/hers	1	2	3	4	5	6	7	N A
13. Fits easily into our work setting	1	2	3	4	5	6	7	N A
14. Stimulates me to see situations in more complex ways	1	2	3	4	5	6	7	N A
15. Relies on one approach to solving problems	1	2	3	4	5	6	7	N A
16. Explains his/her ideas clearly	1	2	3	4	5	6	7	N A
17. Has difficulty understanding my concerns	1	2	3	4	5	6	7	N A
18. Encourages me to try a variety of interventions	1	2	3	4	5	6	7	N A
19. Helps me in ways consistent with my own needs	1	2	3	4	5	6	7	N A
20. Encourages communication between me and others with whom I work	1	2	3	4	5	6	7	N A
21. Increases my understanding of basic psychological principles	1	2	3	4	5	6	7	N A
22. Makes helpful suggestions	1	2	3	4	5	6	7	N A
23. Does not appreciate the pressures of my job	1	2	3	4	5	6	7	N A
24. Makes me feel comfortable in discussing sensitive problems	1	2	3	4	5	6	7	N A

25	Encourages our work group to cooperate	1	2	3	4	5	6	7	N.A.
26	Supports my efforts to solve problems	1	2	3	4	5	6	7	N.A.
27	Has knowledge relevant to my work	1	2	3	4	5	6	7	N.A.
28	Helps me understand myself better	1	2	3	4	5	6	7	N.A.
29	Helps me develop a wider range of problem-solving skills	1	2	3	4	5	6	7	N.A.
30	Rushes into premature solutions	1	2	3	4	5	6	7	N.A.
31	Is sensitive to my feelings	1	2	3	4	5	6	7	N.A.
32	Helps me to see my situation more objectively	1	2	3	4	5	6	7	N.A.
33	Knows how and when to ask good questions	1	2	3	4	5	6	7	N.A.
34	Is reliable about appointments	1	2	3	4	5	6	7	N.A.

This consultant will not be consulting in the future. What suggestions do you have to help him/her improve in consultation skills? Rmember, this information will NOT be used for grading; it will be extremely helpful to your consultant as feedback.

What did you like most about his/her work?
What did you like least about his/her work?
If you did not use this consultant, why not?

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Chapter 6

Issues in Consultation

Introduction

The preceding chapters present information and resources that can serve either as a foundation for the novice consultant or as a systematic framework for the more experienced practitioner. However, there are several other emerging issues which have the potential to significantly influence the direction of consultation as a profession and impact on the work of a beginning or seasoned consultant. Therefore, the purpose of this chapter is to explore three of those issues and explain the import of each area.

The discussion will begin by examining the role of the internal consultant. Since we often think of the consultant as someone outside of an organization or group, frequent comparisons will be made between the external consultant and the internal consultant. The focus in this part of the chapter will be devoted to describing the benefits and limitations of assuming the internal consultant's role.

The next section will emphasize supervising consultants in training. Brown's (1985) comprehensive training model will be stressed since it appears to be the most complete training model available. The reader should note that his model includes a strong theoretical base and specific expectations for the supervisor and supervisee.

The final section in this chapter underscores some of the major issues associated with developing and maintaining a private practice as a consultant. As interest in consultation continues to grow it is likely that a commensurate increase in the number of counselors, counseling psychologists, and other human service professionals who are willing to consider investing a portion or the majority of their paid professional activities to consultative efforts will also grow. Thus, this section will provide coverage of topics that the prospective private consultant may want to review in advance of pursuing opportunities in the field.

Internal Consultant

The roles, functions, and expectations of the internal consultant are marked by ambiguity and the potential for conflict; yet in certain circumstances this professional can be an effective agent for change (Brown et al., 1987; Gallessich, 1982; Pipes, 1981; Steele, 1982).

While the external consultant comes to the consultation process as an outside expert with a unique set of skills specifically related to the organization and an identified problem, the internal consultant has an organizational history and assigned roles which may or may not be a liability in the consulting endeavor. Let us look at these assets and liabilities systematically.

Benefits

The internal consultant has a very large advantage over the external consultant as a result of previous experience with the organization. Internal consultants are likely to know the consultees and forces impacting on the development and maintenance of a presenting problem, as well as the resources available to remediate the particular difficulty. This knowledge can enable the skilled practitioner-consultant to gain the trust and acceptance of consultees in a much shorter period of time. In addition, the internal consultant may have to devote less attention to "selling" organizational leaders and consultees on the efficacy of consultation.

Individuals and groups of consultees can be more cooperative and supportive of someone with whom they are familiar than a "hired gun" brought in to "straighten everything out." The following illustration highlights this form of consultee resistance:

> A private comprehensive mental health clinic brought in a nationally recognized expert in employee relations to help solve the problem of sagging morale among the staff of counseling psychologists. Absenteeism, cancelled appointments by therapists, and a growing number of complaints to administrators about the inattentiveness of therapists to client concerns during counseling sessions had caused a lot of concern. Over the course of a year the outside expert was unable to significantly influence a reduction in the target behaviors associated with low morale. Upon leaving, he expressed his inability to move behond general conversation with the staff of psychologists. About their group sessions, he remarked that they seemed more interested in world affairs and vacation trips than discussion about what brought him to the organization. He also sensed that they appreciated his credentials but did not fully believe that he could understand the problems peculiar to their particular setting.
>
> As a last resort, the administrative team decided to ask the staff psychiatrist to also serve as a consultant to the counseling psychology staff. Because of her previous individual case

consults with the staff, she had no trouble establishing credibility and trust. She was seen as a caring and genuine professional. After establishing her new role with the staff, she quickly decided that the individual meeting format would be best since several of the psychologists had expressed a preference for this style of interacting. As a result, she soon learned that they were concerned about an increasingly top heavy administration that did not allow for input from direct service providers and seemed bent on creating a good public image for the head administrators at the expense of providing sorely needed salary increases and resources for the staff. The psychiatrist and psychologists collaborated on a plan to more actively involve the staff in decision-making processes of the organization. Following adoption of the plan by the administrative team, the rate of absenteeism, cancelled appointments, and client complaints dropped dramatically.

From the illustration, the reader can also see other benefits of the internal consultant's role. For example, the internal consultant, because of a history with the organization, is in a much better position to advocate on behalf of a consultee group. Internal consultants have to "live" with organizational changes so they can have more of a vested interest in shaping resolutions for new behaviors. In addition, unlike the external consultant with only a set of impressive credentials, the internal consultant usually does not have to establish credibility with organizational leaders and consultees. More often than not, the internal consultant will have a positive organizational track record leading to the request for consultation services.

Limitations

Despite the positive features of internal consultation, there are several drawbacks. Gallessich (1982) identified them as follows:

- Income—internal consultants may be more tentative about interventions since their primary source of income is derived from the organization.
- Organizational status and expertise—consultees may not work as effectively with an internal consultant who does not already command a powerful position in the organization structure.
- Objectivity—some internal consultants may already have a set attitude toward a group or individual consultee and have trouble seeing things differently.
- Role conflict—when consultants play several roles, e.g., friend, colleague, supervisor, teacher, cousin, etc., there is a risk of soft pedaling interventions to maintain harmonious relationships in all areas. (pp. 248-250)

To avoid these and other pitfalls, the internal consultant is well-advised to take special care in helping administrators and consultees understand the difference between a regular job assignment and

consultation. It is important that this separation be made clear from the beginning of the consult and repeated as necessary.

Internal consultation is a good way to maximize resources, especially when one time only or short term interventions are necessary. However, thoughtful consideration must be given to issues that minimally effect the external consultant.

Supervising Consultants in Training

Many writers have called for systematic training of consultants and the establishment of empirically based supervisory models (Brown 1985; Dustin, 1985). To date, however, most of our approaches to supervising prospective consultants have been borrowed from supervision models that have been specifically designed for trainees studying individual or group counseling techniques (Boyd, 1978; Goodyear, Bradley, & Bartlett, 1982; Hess, 1980). This state of affairs regarding supervision in the field is understandable given the emerging character of the profession. Nonetheless, it is important that we seriously address the issue given the amount of time most counselors, counseling psychologists, and other professionals are apt to spend consulting (Brown, 1985).

Models

There have been some attempts to isolate and discuss the variables related to successfully supervising consultants (Conoley, 1981; Gallessich, 1980; Kratochwill & Bergan, 1978), but Brown's (1985) model is probably the most comprehensive approach available. His model is based on social learning theory and reciprocal determinism. This approach, the reciprocal relationship model, essentially recognizes the interactive nature of didactic learning, laboratory training, and field placement in shaping future consultants. Specific competencies are described for each of these three modalities. For example, in the didactic training modality he considers models of consultation, assessment strategies, and legal constraints/mandates to be important; in the laboratory training modality the focus is on entry skills, referral procedures, and the design of intervention strategies; and in the field placement modality he recommends attention to the relationship between outcomes of consultation and process, linkages between individuals, subsystems or systems, and the ability to vary style when impingement on the consultation process occurs (p. 413). The reader is reminded that these are but a sampling of the competencies related to the modalities and referred to Brown (1985) for a complete listing of the competencies.

The supervisor's role flows from the competencies expected of students and include (a) establishing explicit standards of performance, (b) modeling complex consultation behaviors, (c) involving the trainee in evaluation processes so that personal standards can be developed, (d) providing immediate feedback, and (e) using a group supervision

format so that students can observe and participate in feedback to others (p. 416).

Brown's (1985) model also accounts for the developmental process of supervision (Littrell, Lee-Bolden, & Lorenz, 1979). He identified the stages that students move through as (a) prerequisite to practicum completed; (b) presupervision assessment of knowledge related to consultation; (c) reteaching as necessary; (d) supervision—entry into supervision, early supervision, middle supervision, late supervision, and evaluation/termination, then articulates how the stages of consultation (relationship/entry, problem identification, goal setting, choice and implementation of strategies, and evaluation and termination) may also be related to the supervisory process.

The supervision of future consultants carries a good deal of responsibility for ensuring the quality of practitioners and thus the stability of a young but growing profession. To be sure, empirically based studies need to be undertaken to test the validity of current approaches and their value to consultee-trainees preparing for work in a variety of settings.

The Consultant As Private Practitioner

Gallessich (1982) has categorized the settings from which consultants come as public-sector or private practice. Within the public sector, the consultants may be internal and thus the employing organization provides the individual's main source of income, while other consultants are engaged in private practice and are employed to provide a variety of services ranging from expert advice to assisting in the diagnosis of organizational concerns. Some persons employed as counselors, professors, or even internal consultants may engage in private practice consultation to some degree. Not only does private practice provide an additional source of income, but also it provides a break from the routine of the everyday assignment.

Organizations may place an informal or formal restriction on time devoted to consulting outside of the organization, so the potential consultant may want to consider discussing plans for engaging in private practice consultation with the appropriate administrators beforehand. Consultants who are essentially full-time employees may also want to guard against overcommitting to consulting activities to the extent that these endeavors negatively impact on the kind and quality of involvement in their home organization. If the consultant's supervisor is forced to repeatedly ask, "Why aren't various tasks being completed?" it is likely that some overextension is occurring. Envious colleagues may also imagine that they are "covering" for the colleague engaged in consulting even though this may be factually incorrect. Wrong or right, this perception by other staff members can cause unnecessary friction. Nonetheless, serving as a consultant to another organization or group can serve as an excellent catalyst for renewal and development.

Other consultants will operate as full-time private practitioners. Johnson (1982) has provided a clear and concise definition of the private practice consultant. She said a private consultant is "a self-employed individual who, for a fee, gives experienced and skilled advice or service in a field of special knowledge or training" (p. 3). This individual may be part of a large organization of consultants, work independently, or work in an organization where consultations with agencies is an expected part of their role. Johnson (1982) states that fully three fourths of private organizations request the assistance of consultants. Since large consulting organizations will typically charge more than the individual consultant, there is a tendency for more and more firms to contract the services of an independent consultant.

The following features highlight some of the more salient factors related to becoming an independent private practice consultant.

Independence

The private practice consultant has an array of choices regarding jobs to accept, rate of payment (hourly, daily, weekly, or flat rate), and the use of other resources (Holtz, 1983). In addition, the independent consultant has more control over a work schedule than the private practice consultant obligated to a group of consultants. Very few occupations are able to provide this kind of freedom and flexibility. On the other hand, independent private practice consultants will need to be self-starters and confident of their abilities (Johnson, 1982). Since they frequently work alone, they will also need to be adept at managing finances, negotiating contracts, and alert for new opportunities.

A Variety of Talents Needed

Johnson (1982) described these talents as:

- Competitor—the ability to successfully recruit new clients.
- Strategist—to plan appropriate interventions and engender support for change throughout the organizational structure.
- Scholar—to study data, recognize patterns, and evaluate outcomes of interventions.
- Teacher—to persuasively present programs and ideas in front of sophisticated managers and undereducated individuals from a variety of backgrounds.
- Listener—since the private practice consultant is often an audience of one, it is important that listening skills be unusually sharp.
- Communicator—one should be a fluent speaker and an excellent writer. Again, there is no one there to clarify.
- Motivator—this person should also be able to change interacting styles so as to facilitate interest on the part of the consultee.

Able to Motivate Consultees

Since the independent private practice consultee is paid a fee, the organization and consultees may want to see results in a shorter period of time. While internal consultants may find consultees resistant and expect the consultant to understand their reluctance to cooperate in remediating a problem, the independent private practice consultant is likely to be viewed as ineffective by consultees and organizational leaders if changes do not seem to be forthcoming.

Ability to Market

Individuals who work as consultants must be goal directed and be self-starters. Large consulting firms have marketing operations, but the individual must market his or her own skills through personal contacts, public service work, speeches, workshops at conventions, and media advertising. After a network has been established, the consultant should work to maintain these relationships by following up on requests for additional information on a subject, follow-up phone calls, and thank-you notes (Tepper, 1985). To be effective these techniques need to be employed on a routine basis even when the consultant loses out to a competitor on a consulting opportunity. Many consultants find this continuous marketing process aversive while others are stimulated by it. Individuals interested in private practice must carefully assess their ability to market their services.

Salable Skills

Potential employers of consultants may be looking for certain areas of expertise or a generalist. Persons considering becoming consultants should carefully assess what skills they have and whether those skills are needed in the marketplace.

Supervision of the Consultant

Once the consultant has verbally accepted an offer to consult for an organization or group, several other matters will need attention:

Contract—It is best to develop a written contract with an employer which at least outlines your duties, pay schedule, length of consultation, confidentiality, and hours/days for the consultation. Some contracts may be quite broad while others can be very specific (Schwitzgebel & Schwitzgebel, 1980). Both kinds of contracts can be effective. A written document should clarify the responsibilities of the consultant and provide a framework for supervision by the appropriate administrator.

Communication—Regularly scheduled meetings should be arranged with the consultant's supervisor to insure that organizational leaders are aware of progress toward goals and any unexpected obstacles that seem to be impeding the consultation effort. Consultants may develop friendships with clients because of their frequent contacts but they should always remember that most supervisors will not hesitate to dismiss a consultant who is not providing services as agreed upon. In

fact, as a general rule, it is advisable to keep professional and personal lives separate (Tepper, 1985).

Assist Your Supervisor

Many supervisors will lack experience with professional consultants or be uncertain of how they can be of help to the consultant other than monitoring their progress and providing resources. After a short visit the consultant should be able to determine how familiar the supervisor is with the consultation process. If the employer has a standard contract, office space, and supplementary reading material about the organization ready for the consultant, it is likely that the supervisor has had some previous work experience with consultants and may be knowledgeable about the consulting process. On the other hand, many supervisors will have limited information about consultation. Regardless of their experience base with other consultants, it is a good idea to help the supervisor understand the key role played by supervisors in the consultation. For example, supervisors can informally and formally endorse the efforts of the consultant. The supervisor who hires a consultant then gives only half-hearted support undermines the consultant and increases the probability of a failed consultation. Supervisors can also be of assistance by notifying the consultant of departments and/or individuals who may pose problems. In this case, an employer may recommend a particular strategy which can become an aspect of an intervention with a troublesome department or individual. A cooperative supervisor can be as helpful as an additional set of eyes and ears in the organization.

Summary

This chapter has addressed three areas which will become more prominent in the profession of consultation: (1) the internal consultant, (2) supervising consultants in training, and (3) the consultant as a private practitioner.

Particular attention was devoted to discussing the benefits and limitations of internal consultation as compared to external consultation. Internal consultation is a good way to enhance the work of an organization or group when resources are in short supply or when lengthy interventions are not required.

Brown's (1985) model for training consultants was explained as an approach which could be used to develop future consultants. His model underlines the importance of traditional classroom learning, opportunities for concrete feedback on specific competencies, and field experiences in the education of consultants.

The last section of the chapter describes some of the major issues that must be confronted by the professional considering part-time or full-time work as a private practice consultant. A careful consideration of these issues may help determine the extent to which an individual may care to commit professionally to this growing area of consultation.

Chapter Seven

Ethical and Legal Considerations in Consultation

There is general agreement that current ethical statements do not provide adequate guidelines for consultants (Brown, Pryzwausky & Schulte, 1987; Gallessich, 1982; Robinson & Gross, 1985). Some call for a separate code of ethics for consultants (e.g., Gallessich, 1982), while others such as Lowman (1985) call for revisions in existing codes. There can be little doubt that those codes of ethics that govern counselors' behavior need revision with regard to consultation. The *AACD Ethical Standards* (1981) are undergoing revision at this time, revisions that will hopefully improve ethical guidelines for counselors. The *NBCC Ethical Guidelines* (1987) have been recently revised, and do provide better ethical guidelines for consultants than those provided by other ethical statements for counselors. The approach taken in this chapter will be to develop a set of ethical principles for counselors, drawing from both the AACD and NBCC codes of ethics.

It can be safely stated that ethical guidelines for consultants are not as fully developed as we would like. It is also safe to say that there are no legal guidelines for the practice of consultation except those that can be derived from cases in related areas such as counseling. Nevertheless, some legal problems that might befall unsuspecting consultants will be identified, and some suggestions made for avoiding potential legal pitfalls.

Background

There is speculation that unethical behavior is widespread among consultants (Gallessich, 1982; Lowman, 1985; Luke & Benne, 1975). It is

certainly true, as Lowman points out, that counselors and others trained only in providing counseling to individuals and small groups have no hesitancy to enter into consulting contracts with individuals, small groups, and various types of businesses and organizations. This is not to suggest that formal training is the only route to the acquisition of consulting skills, for it is probably true that many persons now recognized as experts in the field had little formal preparation in consultation. It is to suggest that the same ethical guidelines should be followed when determining whether or not to act as a consultant as one does in deciding whether or not to engage in counseling.

There have also been suggestions that the reason that unethical behavior among consultants has been tolerated is that there are few standards of practice in the field (Crego, 1985; Gallessich, 1985; Lowman, 1985). As was noted in Chapter One, it is entirely possible to enter into a discussion about consultation with a friend, only to find that you are discussing two somewhat different concepts. It was also noted that this situation is being corrected. So, too, is the idea that there are no standards of practice in the area of consultation.

The empirical literature regarding consultation is growing steadily, particularly in consultation practices in schools (Medway, 1979, 1982). But, as literature reviews (Mannino & Shore, 1975, 1983) suggest, the empirical basis for consultation is not restricted to schools and is, in fact, expanding rapidly in all areas (Kenney, 1986).

These empirical data, plus the judgment of experts, are beginning to provide standards of practice for consultants, and as these emerge, unethical consultants will be increasingly vulnerable. It is also noteworthy that these same standards will increase consultants to legal action, a point that will be taken up in more detail later.

Purposes of Ethical Codes

Ethical codes are developed to provide guidelines so that the individual members of a professional group can regulate their own behavior, and so that the group can also be involved in the regulation process. A code of ethics also provides the general public and regulatory bodies with a set of standards that members are expected to follow. As already noted, the *AACD Ethical Standards* (1981) are woefully inadequate with regard to providing guidelines for ethical behavior in the area of consultation, and while the NBCC Code of Ethics (1987), which governs the behavior of Nationally Certified Counselors (NCC), is somewhat better in this regard, it still is not as definitive as it needs to be.

As Gallessich (1982) points out, the primary impetus for ethical behavior comes from the individual professional, not from a professional organization. Therefore, until more specific ethical guidelines are developed, counselors must follow the intent of their ethical codes rather than looking at the letter of their wording.

Principles of Ethical Conduct in Consultation

Brown and Srebalus (1988) identified seven basic ethical principles that can be found in most codes of ethics, including the *AACD Ethical Standards* (1981), *Ethical Principles of Psychologists* (1981), and the *NBCC Code of Ethics* (1987). These deal with responsibility, competence, public statements, relationships to client groups, relationships to colleagues and other professionals, ethics and the law, and research. Brown et al. (1987), in their discussion of consultation, identified six basic principles which they derived from a number of ethical statements. Not surprisingly, given the overlap in authorship and the general nature of ethical codes, their principles were approximately the same as those identified by Brown and Srebalus, and they do not vary greatly from those posed by Gallessich (1982) or others who have discussed this topic. The discussion that follows will outline the basic ethical principles which should be of concern to consultants.

1. *Consultants should be competent.* As has already been noted here and by others, there are no widely held standards of competence for consultants. However, in most contexts, including an ethical one, competence relates to initial preparation and the maintenance of skills and knowledge through continuing education. Initial and continuing training should develop in the individual a keen sense of their limitations, as well as confidence that they can, in fact, perform certain types of services.

The *NBCC Code of Ethics* (1987) has several statements regarding competency which illustrate this principle. For example, Sections A-7 & -8 state:

> 7. Certified counselors seek only those positions in the delivery of professional services for which they are qualified.
> 8. Certified counselors recognize their limitations and provide services or only use techniques for which they are qualified by training and/or experience. Certified counselors recognize the need and seek continuing education, to assure competent services.

Later in Section E-3 (Consultation) of the same document, the following statement regarding consultation appears:

> 3. Certified counselors must be reasonably certain that they, or the organization represented have the necessary competencies and resources for giving the kind of help that is needed or that may develop later, and that appropriate referral resources are available to the consultant.

For counselors who have had formal preparation in the area of consultation, defining their own competence, and perhaps that of their agency, should pose few problems. For those who have not, the problem becomes one of careful self-assessment of knowledge base and skills. Brown (1985), writing about the preservice training and

supervision, offered a set of knowledge bases and behavioral and judgmental competencies that are needed by consultants. These competencies were generated by the ACES Consultation Interest Network, and are restated here in Figure 9 as questions that can be used to begin to assess one's own competency in this area.

It is not uncommon for counselors who are successful consultants to discuss the generalizability of their counseling skills to the consulting situation. Examination of the list of skills and competencies listed in Figure 9 quickly reveals that this is the case, but it also demonstrates that some unique areas of expertise must be developed before many counselors can hold themselves out to be competent consultants.

Figure 9. Consultation Competency Rating Scale

A. Rate your knowledge base in each of the following areas.

	Rating of Current Skill Level		
	1	2	3
Knowledge Area	Little	Some	Great
1. Models of consultation (e.g., mental health, organizational)	1	2	3
2. Organizational change principles	1	2	3
3. Organizational theory	1	2	3
4. Evaluation strategies	1	2	3
5. Learning theory	1	2	3
6. Group dynamics	1	2	3
7. Ethical standards regarding consultation	1	2	3
8. Information about cross-cultural consultees	1	2	3
9. Legal factors that influence consultation	1	2	3
10. Decision making models	1	2	3
11. Career development theory	1	2	3
12. Referral strategies	1	2	3
13. Human relations models	1	2	3
14. Tests and measurements	1	2	3
15. Conflict resolution models	1	2	3
16. Leadership models	1	2	3
17. Research methodology	1	2	3
18. Theories of individual change	1	2	3
19. Systems theory principles	1	2	3
20. Marketing principles	1	2	3

B. Rate your skill level in each of the following areas.

Competency	Rating of Current Skill Level 1 Little	2 Some	3 Great
1. Relationship-building (general)	1	2	3
2. Cross-cultural relationship building	1	2	3
3. Contract setting (formal/informal)	1	2	3
4. Behavioral assessment	1	2	3
5. Clinical assessment	1	2	3
6. Environmental assessment	1	2	3
7. Motivational skills	1	2	3
8. Designing personal interventions	1	2	3
9. Designing organizational interventions	1	2	3
10. Teaching skills	1	2	3
11. Giving feedback	1	2	3
12. Conflict resolution	1	2	3
13. Conducting staffing/case conferences	1	2	3
14. Interpreting research data	1	2	3
15. Designing surveys	1	2	3
16. Designing cross-cultural interventions	1	2	3
17. Leading small groups	1	2	3
18. Designing marketing strategies	1	2	3

C. Rate your ability to make judgments in the following areas.

Comptency	Rating of Current Judgmental Competency 1 Little	2 Some	3 Great
1. Apply ethical principles to ethical dilemmas	1	2	3
2. Avoid moving into counseling, even though consultee ask for it	1	2	3
3. Select appropriate consultation model, given context	1	2	3
4. Assess problem(s) and set goals	1	2	3
5. Assess data from a variety of sources and synthesize to diagnose problems	1	2	3
6. Recognize consultee resistance and overcome it	1	2	3
7. Recognize need for early termination and terminate with a minimum of stress	1	2	3
8. Identify need for linkages between or among individuals, subsystems, or systems, and help establish these linkages	1	2	3
9. After assessment and goal setting, can design and implement intervention	1	2	3
10. Can evaluate both process and outcomes of consultation using appropriate methodology	1	2	3
11. Interpret evaluation data and recycle consultation as needed	1	2	3

Becoming Competent. A number of authors (e.g., Crego, 1985; Gallessich, 1982) have commented on the inadequacies in consultation training and a recent survey revealed that a majority of counselor education programs still do not offer a course in consultation, although a large percentage do include didactic training in some of their courses (Brown, Spano, & Schulte, 1987). Similarly, nearly one-fifth of the respondents in this survey offer no fieldwork, the setting in which many vital consultation skills must be acquired. It, therefore, has been quite difficult to formally access the experiences needed to become fully competent as a consultant during training, and training experiences are not widely available to those already in the field.

Informal apprenticeships offer viable alternatives to formal experiences in the development of consultation skills, particularly when they are accompanied by a rigorous program of reading and participation in workshops. AACD has offered some workshops in consultation, and will continue to do so. The American Society for Training and Development should also be considered as a source of valuable training experiences to develop or sharpen consultation skills.

2. *Consultants protect the welfare of their consultees and the clients served by the consultees.* As can be readily recognized, the consultant has a double-barreled responsibility in the consulting process. The NBCC (1987) spells out this responsibility to the consultation in section E-2 (Consulting) as follows:

> 2. In the consulting relationship the certified counselor and client (consultee) must understand and agree upon the problem definition, subsequent goals, and predicted consequences of the intervention.

It is in the area of the predicted consequences of the intervention that the consultant's second area of consequences comes into play, that is, the responsibility to the client.

Protecting the welfare of the consultee begins with entry into the consulting relationship. In some instances, consultation has been "suggested" by a superior and, thus, the consultee becomes an unwilling victim of the process. The *NBCC Code of Ethics* (1987) defines consultation as a "voluntary" relationship and, thus, consultants need to recognize the rights of the consultee to be a willing participant in the process, or be functioning unethically.

Protecting the welfare of the consultee also involves fee-setting, since the *AACD Code of Ethics* (1981) admonishes counselors to establish fees with the welfare of the person(s) being served in mind. Thus, in the initial phase of counseling, setting fees that are acceptable to the client and determining the voluntariness of the relationship are key factors to consider.

Considering consultee welfare is also contingent upon avoiding dependency relationships. The *NBCC Code of Ethics* (1987) contains the following statement (E-4):

4. Certified counselors in a consulting relationship must encourage and cultivate client (consultee) adaptability and growth toward self-direction. Certified counselors must maintain this role consistently and not become a decision maker for clients or create future dependency on the consultant.

One goal of consultation is to develop a consultee who can function independently of the consultant, but there may be a tendency for some consultants to foster this dependency to meet their own needs for power, money, or influence (Gallessich, 1982). Dependency relationships may develop whenever the consultant assumes consultee roles in the assessment, goal setting, and strategy implementation process.

Stereotyping consultees is also to be avoided (AACD, 1981), since it is basically dehumanizing. Gibbs (1985) points out that stereotyping is likely to occur in cross-cultural settings because few training programs offer adequate training in this area. However, experience suggests that stereotyping is not constrained to cross-cultural situations and that consultants may hold stereotypes of certain occupational groups or people in certain industries.

Just as consultants work with consultees to determine whether or not they have volunteered for the process, the consultant needs to work with the consultee to determine whether the client will benefit from the consulting relationship. It should be noted that this statement stops just short of demanding that the client be a voluntary participant. This is because, in some consultations such as those with teachers, prison officials, and in other settings, this would not be possible. In fact, one aspect of the consultation may focus on motivating a recalcitrant client to become actively involved in the process.

Protecting the welfare of the client involves making certain that any action promulgated does not violate the human rights of the client, and that the intervention will be accepted in the cultural and organizational context of the client. It also involves assessing the unintended consequences of an action (Gallessich, 1982; Robinson & Gross, 1985). For example, a teacher may wish to reduce the aggressiveness of a child when, in fact, aggressiveness is a survival skill in that child's environment. The teacher's middle-class values may not provide appropriate guidelines for children's behaviors in some situations.

Protecting the welfare of the consultee and client also means being careful not to intrude into their privacy. Therefore, whenever surveys are conducted as a part of problem identification or evaluation efforts, every effort must be made to ensure that involvement is voluntary.

3. *The consultant maintains confidentiality of all disclosures.* Confidentiality of communication is one of the most basic of all

ethical principles of consultation. Both the AACD (1981) and NBCC (1987) ethical statements stipulate that information gained in counseling is to be held in confidence unless permission to disclose that information is secured. While one *could, and should,* infer that this confidentiality should extend to the consulting relationship, neither set of ethical principles makes this clear.

Confidentiality is, in a real sense, a key feature of protecting the welfare of both the consultee and client. It is also essential for the maintenance of the integrity of the consulting relationship. Therefore, confidentiality in communication should be included in the formal consulting contract, if one is negotiated. If no formal contract exists, the consultant should clarify the consultee's expectations regarding confidentiality and communicate clearly that, not only will the communication between consultant and consultee be held in confidence, but communication between the consultant and others with whom the consultant comes into contact, in activities such as problem diagnosis, will be held in confidence.

Confidentiality also extends to data collection efforts such as needs assessments, problem identification surveys, and evaluations. In these cases, it is doubtful that the integrity of the data can be guaranteed unless confidentiality is maintained and, thus, confidentiality takes on an added significance.

Finally, consultants will be involved in either using electronic data collection systems or, in some instances, helping to design them. While these systems have great potential for reducing clerical time and for improving services, unless they are properly designed, they also have great potential for harm or invasion of privacy. One company established a computerized career exploration system that allowed employees to take interest inventories and to engage in a computerized career exploration. However, this system was designed so that managers in the corporation could access the data generated. There is nothing wrong with a system of this type *if* the employees are aware that the data may be used in selecting individuals for various types of jobs. Where the danger occurs is when all concerned are not fully aware of the consequences.

The following section from the *NBCC Code of Ethics* (1987) summarizes this point succinctly (B-6):

> 5. Certified counselors must ensure that data maintained in electronic storage are secure. The data must be limited to information that is appropriate and necessary for the services being provided and accessible only to appropriate staff members involved in the provision of services by using the best computer security methods available.

4. *The consultant upholds the highest moral and legal standards.* Almost all codes of ethics now warn against sexual harrassment and/or involvement with those served (e.g., AACD, 1981; NBCC, 1987). Similarly, counselors are admonished to avoid relationships that may

result in conflicts of interests and to follow the moral and legal standards of their communities. Unfortunately, because of the nature of consultation, these rather general statements are not sufficient.

Backer and Glaser (1979) identified nineteen pitfalls for consultants, many of which fall into the moral and ethical area. For example, some consultants prolong consultation because of the money involved. Others fail to take stands against illegal or unethical behavior for the same reason. Still others lose their objectivity and become involved in the politics of the organization, while some consultants alter evaluation data. Some consultants resist evaluation altogether, fearing that the result will highlight their failure and result in termination.

It may be apparent that the primary reason that consultants function unethically is because they are trying to meet their own needs rather than meeting the needs of their consultees. Both the AACD (1981) and NBCC (1987) codes of ethics suggest that counselors must be aware of their own needs. For example, E-1 of the NBCC code states:

> 1. Certified counselors, acting as consultants, must have a high degree of self-awareness of their own values, knowledge, skills, limitations, and needs in entering a helping relationship that involves human and/or organizational change.

Awareness is, of course, the first step. Recognizing ethical pitfalls and acting to avoid them is perhaps the highest judgmental competency that consultants must demonstrate. However, morality becomes an issue when the counselor deliberately engages in unethical or illegal practice or ignores those who do.

5. *Consultants recognize their responsibility to other consultants and act in accord with ethical guidelines in their professional dealings.* The first responsibility that consultants have to other professionals is to recognize their value and worth regardless of the discipline or specialty. Consultants come from adult and higher education, industrial psychology, psychiatric nursing, clinical and counseling psychology, social work, engineering, business, etc. There is a tendency to stereotype consultants and their expertise based on their origin. This must be avoided.

A second responsibility is to recognize unethical conduct and take appropriate action to make certain that it does not continue. Usually, correcting the unethical behavior begins with contacting the consultant who is practicing unethically, pointing out the behavior, and asking them to correct the situation. If this is not sufficient, then professional ethics committees should be notified. Letters informing ethics committees of inappropriate behavior should include precise descriptions of the unethical behavior and sections of the ethical code being violated. The ethics committee will then investigate the charge, usually beginning by requesting the person charged to give his or her perceptions of the situation. Once data are collected, the case will be adjudicated and a decision rendered.

Third, and finally, counselors have responsibility to other professionals and to their profession. The NBCC (1987) code indicates that counselors "must be aware that all actions and behaviors of the counselor reflect on professional integrity and, when inappropriate, can damage the public trust in the counseling profession" (Section A-12). In some instances, counselors have been reluctant to cite other counselors for unethical behavior. As the importance of ethical conduct to the profession becomes fully recognized, this reluctance will surely give way to vigorous enforcement of ethical principles.

6. *Consultants make accurate public statements about their credentials.* Currently, the AACD (1981) code of ethics contains no statement about public statements or advertising, a situation that may be corrected shortly. However, the NBCC code contains two helpful statements in this regard:

> A-4. Certified counselors neither claim nor imply professional qualifications which exceed those possessed, and are responsible for correcting any misrepresentation of these qualifications by others.
>
> F-4. Certified counselors may list their highest relevant degree, type and level of certification and/or license, address, telephone number, office hours, type and/or description of services, and other relevant information. Listed information must not contain false, inaccurate, misleading, partial, out-of-context, or otherwise deceptive material or statements.

These two statements imply correctly that one's credentials are presented in three ways: formally by the counselor, informally by the counselor, and by others. They also provide guidelines for each situation.

It is reasonably easy to imply qualifications beyond those held when informally presenting one's qualifications. Counselors anxious to land lucrative consultation contracts may simply imply experience, background, and other credentials that are misleading. Sometimes this is done, not through acts of commission, but rather through omission. Counselors do not fully inform prospective consultees that they are inadequately prepared to deliver the service in question. In either case, the consultant is acting unethically.

In some instances, others present the consultant's credentials to prospective consultees. A teacher may tell another teacher that a consultant has extensive experience in working with learning disabled children. A counselor may be introduced as a counseling psychologist. A person with a master's degree is referred to as Doctor Smith. These situations occur frequently. The consultant's responsibility is to set the record straight at the earliest moment. In some instances, this can be done immediately just by correcting the person who has made the introduction. In other instances, more formal actions may be called for, such as the situation where a person without a doctorate is so listed in a conference program.

Business cards, advertisements such as those placed in the yellow pages of telephone directories, and the letterhead of stationery are developed to put the consultant's best foot forward. That is not a problem so long as the information provided is accurate. However, providing false information or making false claims about the value of services provided is forbidden.

One final concern about public statements is with regard to partnership and corporations. Advertisements and materials must make it clear what specialties are held by the persons involved. Otherwise, the public could be misled.

Legal Concerns

Criminal Legal Concerns

Consultants' legal concerns fall into two general categories: criminal and civil. Criminal actions are likely to be brought against consultants such as income tax evasion, fraud, and being an accessory to a crime. Charges of fraud may arise because of misrepresentation of credentials, over-billing, or other acts involving deceit. Being an accessory to a crime occurs when a consultant is aware that a crime is either about to be, or has been, committed and does not take appropriate action. Avoiding criminal charges is a matter of being aware of the general legal statutes in this country and acting according to their directives.

Civil Legal Concerns

Consultants have not proven to be as vulnerable to civil suits, to date, and it is unlikely that this situation will change in the foreseeable future because standards of practice have not been clearly established and, thus, there is generally a lower expectation of functioning in this area. However, Brown et al. (1987) identified several areas where consultants may be open to civil legal action if they do not adhere rigidly to their ethical codes and do not apply common sense principles.

Many consulting jobs awarded by external contracts involve establishing formal contracts between the consultant, the consulting firm, and the consultee. This contract needs to be carefully drawn, to protect both parties, and adhered to rigidly. Basically, the contract should contain the following items:

1. Identify the consultee and consultant.
2. Beginning and ending date of contract.
3. Products to be produced (e.g., reports, surveys, etc.) and due date of the products.
4. Stipulations regarding who owns products (consultant, consultee, joint).
5. Amount, method, and date of payment for services. Work to be completed for services.

6. Site at which work is to be conducted and responsibility for facility and work site.
7. Stipulation that consultant is not an employee and is, in fact, an independent contractor.
8. Paragraph regarding confidentiality of communication, as well as statement forbidding consultant to disclose information about the consultee to outside sources.
9. Assignability, if any, of the consulting work should be covered. This includes provisions for sub-contracting of the work.
10. Method of arbitration of disputes, if any, should also be covered.
11. Termination of the contract prior to the termination date specified in the contract should be set forth.
12. Method by which contract conditions can be changed.

Contracts, once drawn, should be signed, dated, and witnessed in order to become legal documents. Once in place, the contract provides guidelines for the consultant and consultee.

Some consultants operate more informally, believing that a verbal agreement and a handshake are sufficient for conducting business. Breach of contract suits can grow out of these types of relationships just as they do out of more formally drawn contractual arrangements. Generally, it is recommended that more formal arrangements be entered into prior to initiating consultation.

Malpractice occurs whenever a consultant has a duty, breaches that duty, and a loss occurs (Hopkins & Anderson, 1985). Consultants' duties are spelled out in their general codes of conduct (e.g., ethical statements) and in their formal and informal contracts. Duties also grow out of standards of practice in a given area. Malpractice can grow out of "sins" of omission or commission. Failure to alert a consultee that a client may be dangerous would be an example of the former, while utilizing inappropriate procedures would be illustrative of the latter.

Loss can be defined as psychological, physical, monetary, or as a reduction in status. A consultee who suffers a loss of self-esteem, or actually suffers a demotion, could suffer psychological, monetary, and status losses.

In malpractice suits, it is the obligation of the plaintiff's attorneys to establish a causal link between the breach of duty and loss (Hopkins & Anderson, 1985). Because of the complexity of most consulting situations, this would be difficult, although not impossible, to do. Also, the plaintiff, in establishing the duty, must establish that the consultant has deviated significantly from standards of practice in consulting. In the final analysis, this may be harder to accomplish.

Defamation, sexual misconduct, and wrongful invasion of privacy could also result in the launching of successful civil suits. Defamation involves disseminating untrue information about an individual that

results in real or psychological damage and loss. Written defamation is libel, while oral defamation is slander. Consultants who spread false information about consultees might encounter this difficulty. Invasion of privacy could result when tests, inventories, and surveys are administered without full consent, and the result of sexual misconduct has been well-established in the counseling literature.

Consultants are far more likely to become embroiled in ethical allegations than they are in legal suits, although the two often occur together. However, because of the legalization of our society, it is advisable for consultants to protect themselves, both by acting ethically, and by investing in a substantial malpractice insurance policy.

Summary

While codes of ethics governing counselor behavior have not fully addressed the consulting relationship, certain principles can be extracted from existing documents that can provide useful guidelines. However, it is the basic moral integrity of the counselor that will guide his or her behavior in the presence or absence of clear-cut ethical principles.

Legal guidelines for consultants are less clear than ethical principles, which is to say that few, if any, consultants have encountered legal problems. It is likely that consultants will increasingly encounter legal difficulties in the future, particularly if they ignore good ethical practice.

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